HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE

NOT TO CIRCULATE

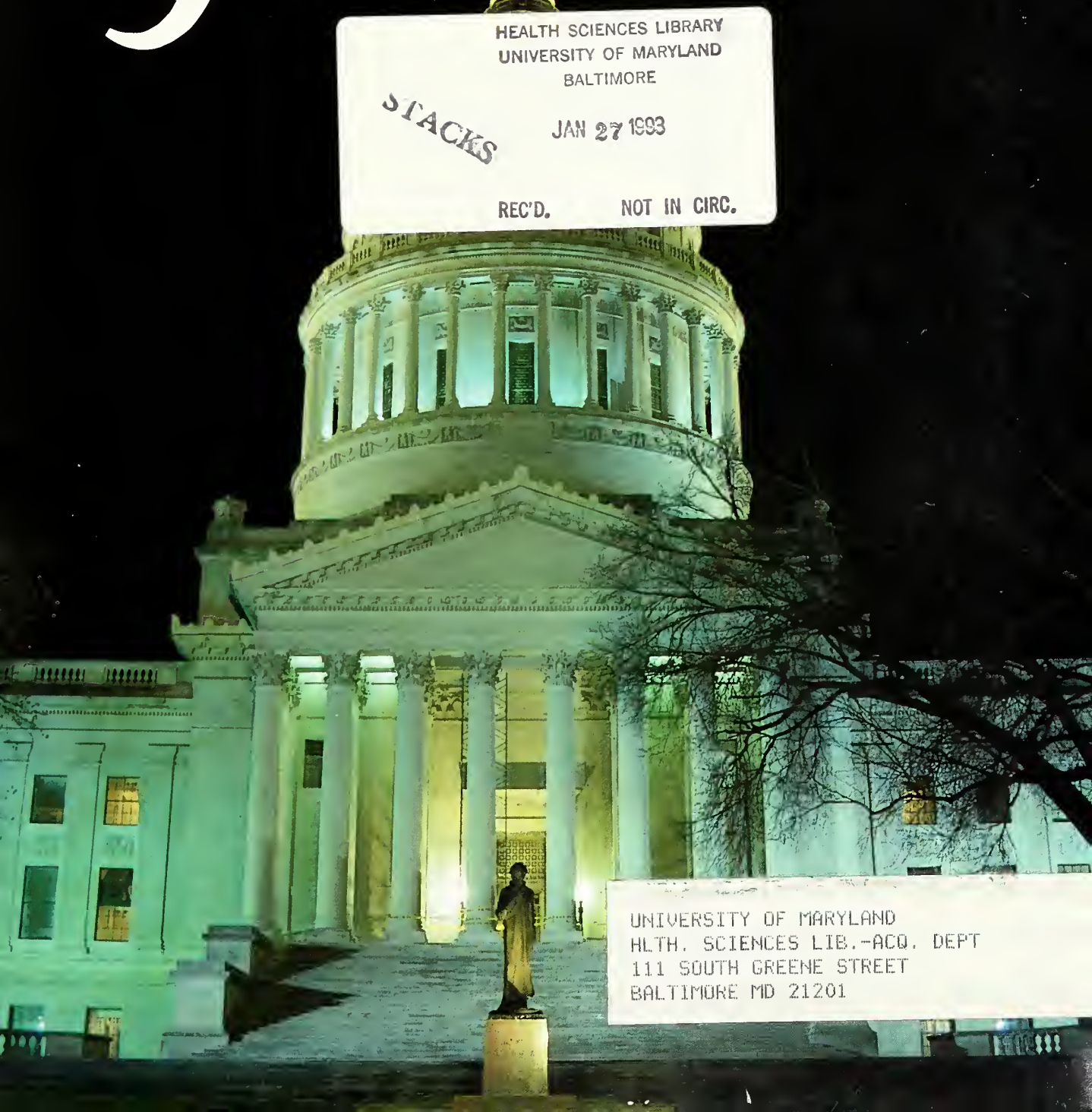
HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE

NOT TO CIRCULATE

West Virginia Medical JOURNAL

January 1993 West Virginia State Medical Association Volume 89 No. 1

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE
STACKS
JAN 27 1993
REC'D. NOT IN CIRC.

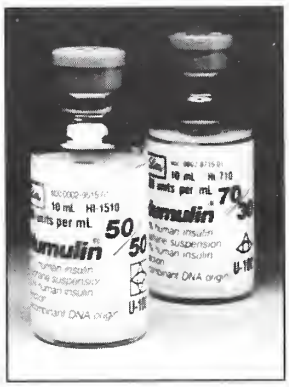


UNIVERSITY OF MARYLAND
HLTH. SCIENCES LIB.-ACQ. DEPT
111 SOUTH GREENE STREET
BALTIMORE MD 21201

Because One Size Doesn't Fit All...

New Humulin 50/50 is the tailor-made answer to individual patient needs. A unique combination of equal amounts of Regular human insulin and NPH human insulin, it will be useful in situations in which a greater initial insulin response is desirable for greater glycemic control.

Like Humulin 70/30*, new Humulin 50/50 offers the convenience and accuracy of a premix. And it can be used in conjunction with an existing 70/30 regimen.



New Humulin® 50/50

50% human insulin isophane suspension
50% human insulin injection (recombinant DNA origin)

The Newest Option in Insulin Therapy

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

* Humulin® 70/30 (70% human insulin isophane suspension, 30% human insulin injection [recombinant DNA origin]).

Lilly

Global Excellence in Diabetes Care
Eli Lilly and Company
Indianapolis, Indiana
46285

HI-7911-B-249343 © 1992, ELI LILLY AND COMPANY

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA
MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article

Evaluation of the obstetrical care system in West Virginia . . . 6

Scientific Newsfront

Double cheek-cervical rotation flap for repair of facial defects
Romeo Y. Lim, M.D., F.A.C.S.; Samuel A. Strickland, M.D.; and Jessica W. Lim, M.D. . . . 18

The use of modern radiologic methods in identifying incidental renal cell carcinoma
Steven J. Jubelirer, M.D., and Marc Rubin, MSIII

New Manuscript Guidelines . . . 20

President's Page

WORDS . . . 24

Editorial

Peace . . . 25

Departments

General News . . . 26
Continuing Medical Education . . . 32
Medical Meetings/Poetry Corner . . . 33
Bureau of Public Health News . . . 34
WVU Health Sciences Center News . . . 36
MU School of Medicine News . . . 38
Auxiliary News . . . 40
WESPAC Members . . . 42
Obituaries . . . 43
Classified . . . 45
January Advertisers . . . 46

Front Cover

The spectacular night-time view of the State Capitol from Kanawha Boulevard. Photo courtesy of *Robbie Parsons*, South Charleston, WV.

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA
MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article

The saga of rural health care 54

Scientific Newsfront

An epidemic of caterpillar sting dermatitis in a rural West Virginia community
Robert B. Walker, M.D.; Tim Thomas, M.D.; Dennis Cupit, MSIV; and Jennifer Giaquinto-Shreves, MSIII 58

Hypercoagulable states (Medical Grand Rounds from West Virginia University Health Sciences Center, Edited by Irma H. Ullrich, M.D.)
John S. Roger II, M.D. (Discussant) 61

New Manuscript Guidelines 60

President's Page

The "T" word 64

Editorial

The Medical Community? 65

Our Readers Speak

State physicians deserve a level playing field 66

Departments

General News 68
Continuing Medical Education 72
Medical Meetings/Poetry Corner 73
Bureau of Public Health News 74
WVU Health Sciences Center News 76
MU School of Medicine News 78
Medical Student News 80
New Members/County Societies 82
Obituaries 83
Advertising Rates 84
Classified 85
February Advertisers 86

Front Cover

Beautiful snow-covered Marsh Fork Falls at Twin Falls State Park in Wyoming County. Photo courtesy of *Scott Durham* of Pineville, West Virginia.

Digitized by the Internet Archive
in 2016 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/westvirginiamedi8911west

)ITOR
ephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

ANAGING EDITOR
ıncy L. Hill, Charleston

XECUTIVE DIRECTOR
eorge Rider, Charleston

SSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

ESIDENTS,
UBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

DVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Special Section

Highlights of the WVSMA's 1993 Mid-Winter Clinical Conference 94

Scientific Newsfront

An analysis of 38 cases of low-grade cerebral astrocytoma in adults
Steven J. Jubelirer, M.D.; Mark Rubin, MSIII; and Chull Shim, M.D. 102

Indications for carotid endarterectomy
Howard H. Kaufman, M.D., and Joseph L. Voelker, M.D. 106

New Manuscript Guidelines 108

Nd:Yag laser surgery of venous malformations
Romeo Y. Lim, M.D., F.A.C.S. 109

President's Page

??????????? 112

Editorial

Making Sense 113

In My Opinion

If elective abortion is not wrong, nothing is wrong 114

Special Departments

General News 116
Continuing Medical Education 118
Medical Meetings/Poetry Corner 119
Bureau of Public Health News 120
WVU Health Sciences Center News 122
MU School of Medicine News 124
Auxiliary News 126
New Members/County Societies 128
Obituaries 129
Classified 133
March Advertisers 134

Front Cover

A bright blue sky filled with fluffy white clouds heralds the beginning of spring in Renick in Greenbrier County. Photo courtesy of *Scott Durham* of Pineville, West Virginia.

DITOR
ephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

ANAGING EDITOR
ancy L. Hill, Charleston

XECUTIVE DIRECTOR
eorge Rider, Charleston

SSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

ESIDENTS,
UBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

DVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

HE WEST VIRGINIA
IEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article

Kanawha County launches mini-internship program 142

Scientific Newsfront

Radiofrequency catheter ablation for recurrent ventricular tachycardia
Ronald McCowan, M.D. 144

Choroidal metastasis from primary mucinous cystadenocarcinoma of the ovary
Curtis D. White, M.D.; Warren L. Cooper, M.D.; Rodney R. Williams, M.D.; and Albert B. C. Flemming, M.D. 146

New Manuscript Guidelines 147

Therapy for congestive heart failure in the late 20th century (Medical Grand Rounds from West Virginia University Health Sciences Center, Edited by Irma H. Ullrich, M.D.)
L. Phillips Maxwell, M.D.
Abnash Jain, M.D. (Discussants) 148

President's Page

We - Them, Sunshine and the Orange and Black 154

Editorial

Congressional need 155

Our Readers Speak

A different perspective on obstetrical data 156

Special Departments

General News 160
Continuing Medical Education 164
Medical Meetings/Poetry Corner 165
Bureau of Public Health News 166
WVU Health Sciences Center News 168
MU School of Medicine News 170
Medical Student News 172
Obituary/County Societies 174
Classified 177
April Advertisers 178

Front Cover

A barn owl perches on a stump on the grounds of the Three Rivers Raptor Rehabilitation Center near Hinton in Summers County. Photo courtesy of *David Fattaleh*, West Virginia Division of Tourism and Parks.

:DITOR
tephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

ANAGING EDITOR
Jancy L. Hill, Charleston

:XECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article
Confessions of a rookie 186

Scientific Newsfront
Herpes esophagitis in immunocompetent adults: Report of two cases and review of the literature
Sandra Y. Elliott, M.D.; Fred T. Kerns, M.D.; and Lynn W. Kitchen, M.D. 188

Simplified method of evaluating dysfunction in St. Jude medical prosthetic heart valves
Mark J. Hermacinski, M.D.; and L. Gonzalez-Lavin, M.D., F.A.C.S., F.A.C.C., F.A.C.C.P., F.A.A.P. 191

An "above ground" pool hazard
Harvey D. Reisenweber, M.D. 194

President's Page
The Medicaid gridlock 196

Editorial
Frank J. Holroyd, M.D., R.I.P. 199

Guest Editorial
Deeefense 200

Our Readers Speak 200

Special Departments
General News 204
Continuing Medical Education 208
Medical Meetings/Poetry Corner 209
Bureau of Public Health News 210
WVU Health Sciences Center News 212
MU School of Medicine News 214
Auxiliary News 216
New Members/WESPAC Members 218
Obituary 219
Classified 221
May Advertisers 222

Front Cover
Rose dragon head in bloom at Twin Falls State Park in Mullens, W.Va. Photo courtesy of *Scott Durham* of Pineville, W.Va.

DITOR
ephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

ANAGING EDITOR
ancy L. Hill, Charleston

XECUTIVE DIRECTOR
eorge Rider, Charleston

SSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

ESIDENTS,
UBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

DVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Scientific Newsfront

Video-assisted thoracoscopy: A major advance in diagnosis and treatment of intrathoracic pathology
Gerald G. Tanguilig, MSII; David R. Jones, M.D.; and Geoffrey M. Graeber, M.D., F.A.C.S. 230

The chemohormonal therapy of metastatic melanoma: Possible benefit of tamoxifen
Edward B. Crowell Jr., M.D., F.A.C.P.; and Gerald M. Higa, Pharm. D. 233

New Manuscript Guidelines 235

Cystic fibrosis: Current concepts
Medical Grand Rounds from West Virginia University Health Sciences Center, Edited by Irma H. Ullrich, M.D.
Henry L. Abrons, M.D. (Discussant) 236

President's Page

Policies! 242

Editorial

Circling buzzards 243

In My Opinion

OMA offers physicians a means of survival 244

Our Readers Speak

Comparison of infant mortality rates meaningless 244

Special Departments

General News 248
Continuing Medical Education 254
Medical Meetings/Poetry Corner 255
Bureau of Public Health News 256
WVU Health Sciences Center News 258
MU School of Medicine News 260
Obituary/Society News 262
Classified 265
June Advertisers 266

Front Cover

A turtle gazes at the greenery at Kanawha State Forest near Charleston. Photo courtesy of *Robbie Parsons,* South Charleston, W.Va.

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal*.

Postmaster send form 3579 to the *West Virginia Medical Journal*, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal*, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Articles

How the Health Care Surrogate Act of 1993 will simplify medical care in West Virginia 274

Sexual Misconduct Statement of the West Virginia Board of Medicine[1] 276

Scientific Newsfront

An implication for bone posterity: Dietary calcium intake in medical personnel in southern West Virginia
Alfred K. Pfister, M.D., F.A.C.P. 280

Papillary intraperitoneal neoplasia resembling ovarian carcinoma after removal of benign ovaries
Curtis D. White, M.D. 282

Report of *Pseudomonas aeruginosa* sinusitis in a patient with AIDS
R. Wesley Farr, M.D.
Hassan H. Ramadan, M.D. 284

President's Page

Anecdotes and political clout 286

Editorial

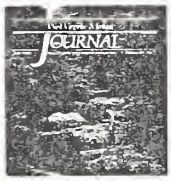
Conservatism and Medicine 287

Teaching Case

Mountaineer's choice 288

Special Departments

General News 290
Physician's Recognition Awards 293
Continuing Medical Education 296
Medical Meetings/Poetry Corner 297
Bureau of Public Health News 298
Robert C. Byrd Health Sciences Center News 300
MU School of Medicine News 302
Medical Student News 304
Obituary/Society News/New Members 306
Advertising Rates 308
Classified 309
July Advertisers 310



Front Cover

A hiker enjoys the scenic beauty at Babcock State Park in Fayette County. Photo courtesy of *Larry Belcher*, West Virginia Division of Tourism and Parks.

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Special Article
WVSMA staff members highlighted 318

Special Reports
An overview of the AMA Annual Meeting 320
An overview of the HMSS Annual Meeting 321

Scientific Newsfront
Supraventricular tachycardia: Catheter ablation in 72 patients 324
Safety belt use and hospital charge differences among motor vehicle crash victims 328
Manuscript Guidelines 330
Chlamydia trachomatis genital infections
Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of West Virginia University 331

President's Page
Medical system failure? 336

Editorial
No reality except in action 337

Our Readers Speak
Carotid endarterectomy article needs clarification 338

In My Opinion
Difficult recovery from addiction made easier by support of my peers 340

Special Departments
General News 342
Annual Meeting Information 349-355
Continuing Medical Education 356
Medical Meetings/Poetry Corner 357
Bureau of Public Health News 358
Robert C. Byrd Health Sciences Center of WVU News 360
Marshall University School of Medicine News 362
Auxiliary News 364
Obituaries 366
Classified 369
August Advertisers 370

Front Cover

Three guests depart from The Greenbrier for a scenic horseback ride. Photo courtesy of *Stephen J. Shaluta Jr.,* West Virginia Division of Tourism and Parks.

DITOR
tephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

IANAGING EDITOR
Iancy L. Hill, Charleston

XECUTIVE DIRECTOR
George Rider, Charleston

SSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal*.

Postmaster send form 3579 to the *West Virginia Medical Journal*, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal*, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article
1993 West Virginia family practice residents: Demographics and future plans 378

Scientific Newsfront
Management of residual squamous intraepithelial lesions of the cervix after conization 382
Competency assessment in the elderly 386
Manuscript Guidelines 388
Hepatitis B surface antigen prevalence in blood samples tested at Cabell Huntington Hospital 389

President's Page
Communication: A two-way street 392

Editorial
Know the law regarding the new DNR Act! 394

In My Opinion
Doctors and the Legislature 395

Special Departments
General News 398
Continuing Medical Education 402
Medical Meetings/Poetry Corner 403
Bureau of Public Health News 406
Robert C. Byrd Health Sciences Center News 408
Marshall University School of Medicine News 410
Medical Student News 412
Obituaries 414
Classified 417
September Advertisers 418

Front Cover

Teasel silhouetted against a spectacular sunset in Mullens, W.Va. Photo courtesy of *Scott Durham* of Pineville, W.Va.

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal*.

Postmaster send form 3579 to the *West Virginia Medical Journal*, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal*, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Special Section • Convention Report
Photo Highlights 428-435
1993 Resolutions 436
Annual Reports 438

Scientific Newsfront
The changing pattern of early breast cancer and its primary management at CAMC 442
Management of deep vein thrombosis of the lower extremity in pregnancy 445
Manuscript Guidelines 447
Breast cancer - A medical disease? Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of West Virginia University 448

President's Page
"The Plan" means Americans must make tough choices . . . 454

Editorial
Health care disaster 455

Our Readers Speak
Actual courses??? 456
Time to set term limitations 456

In My Opinion
Why I'm joining the physicians union 457

Special Departments
General News 460
Continuing Medical Education 464
Medical Meetings/Poetry Corner 465
Bureau of Public Health News 466
Robert C. Byrd Health Sciences Center News 468
Marshall University School of Medicine News 470
Obituaries 472
Society News 472
1992 Annual Audit 474
Classified 477
October Advertisers 478

Front Cover

A picturesque fall setting is found at the Glade Creek Grist Mill in Babcock State Park. Photo courtesy of *Scott Durham* of Pineville, W.Va.

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article
Roll call votes affecting health care providers 486

Scientific Newsfront
Update on therapy for atrial fibrillation 490
Manuscript Guidelines 493
Giant posterior inferior cerebellar artery aneurysm associated with foramen magnum syndrome 494
The gynecologist and treatment of carcinoma of the breast 496

President's Page
WVSMA advocates change 500

Editorial
The split in medicine 502

In My Opinion
Clinton plan unnecessarily complex 503

Special Departments
General News 504
Mid-Winter Clinical Conference Preliminary Program 506
Mid-Winter Clinical Conference Registration Form 507
Continuing Medical Education 508
Medical Meetings/Poetry Corner 509
Bureau of Public Health News 512
Robert C. Byrd Health Sciences Center News 514
Marshall University School of Medicine News 516
For Your Benefit 518
Alliance News 520
Obituary/Society News 521
New Members/WESPAC Members 522
1994 Advertising Rates 524
Classified 525
November Advertisers 526

Front Cover

A river otter takes a break from swimming at French Creek Game Farm in Upshur County. Photo courtesy of *Stephen J. Shaluta Jr.,* West Virginia Division of Tourism and Parks.

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENT EDITOR
Linn M. Mangano, M.D., Morgantown

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article

Medical informatics and the rural physician 534

Scientific Newsfront

PH monitoring experience in children with gastroesophageal reflux 538
Manuscript Guidelines 541
Cancer mortality in West Virginia 542
An incidental finding of extreme self-limited thrombocytosis of unknown cause 545

President's Page

Make your opinions heard! 548

Editorial

No, Thank You! 549

Special Departments

General News 550
Managed Care Workshop Registration Form 554
Mid-Winter Clinical Conference Registration Form 555
Continuing Medical Education 556
Medical Meetings/Poetry Corner 557
Bureau of Public Health News 558
Robert C. Byrd Health Sciences Center News 560
Marshall University School of Medicine News 562
Medical Student News 564
1993 Index of Scientific Authors 566
1994 Advertising Rates 568
Classified 569
December Advertisers 570

Front Cover

The brilliant Christmas lights decorating the State Capitol and the Governor's Mansion create a festive holiday scene in Charleston. Photo courtesy of *Robbie Parsons,* South Charleston, W.Va.

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA
MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article

Evaluation of the obstetrical care system in West Virginia . . . 6

Scientific Newsfront

Double cheek-cervical rotation flap for repair of facial defects
Romeo Y. Lim, M.D., F.A.C.S.; Samuel A. Strickland, M.D.; and Jessica W. Lim, M.D. . . . 18

The use of modern radiologic methods in identifying incidental renal cell carcinoma
Steven J. Jubelirer, M.D., and Marc Rubin, MSIII

New Manuscript Guidelines . . . 20

President's Page

WORDS . . . 24

Editorial

Peace . . . 25

Departments

General News . . . 26
Continuing Medical Education . . . 32
Medical Meetings/Poetry Corner . . . 33
Bureau of Public Health News . . . 34
WVU Health Sciences Center News . . . 36
MU School of Medicine News . . . 38
Auxiliary News . . . 40
WESPAC Members . . . 42
Obituaries . . . 43
Classified . . . 45
January Advertisers . . . 46

Front Cover

The spectacular night-time view of the State Capitol from Kanawha Boulevard. Photo courtesy of *Robbie Parsons*, South Charleston, WV.

Evaluation of the obstetrical care system in West Virginia

ROBERT P. PULLIAM, M.D.
President, West Virginia State Medical Association; OB/GYN, Beckley

Introduction

Agreement on the evaluation of obstetrical health care in West Virginia appears to depend on the observer and his or her particular orientation to the problem. Is it possible to objectively evaluate the system, or does the evaluation depend on the criteria used?

The best evaluation may be like the "best spouse – it all depends on what one is looking for." Physicians may assign far different values than the public. Naturally, different criteria has been used to evaluate health care and includes:

1) Maintenance and technical standards in diagnoses and treatment,
2) Preventive measures and reassurance of essentially healthy patients,
3) Rehabilitation and nursing care for the sick and disabled,
4) Access to primary care,
5) Health indicators (public health),
6) Public satisfaction,
7) Technology,
8) Service and;
9) Efficiency and distributional equity.

While all of these criteria may be valid indicators in the evaluation of health care, hard data is limited in most. Where data is limited, conclusions are more likely to be influenced by bias. Several of these indicators – access to care, health indicators, technology, and possibly distributional equity and efficiency – appear to have adequate hard data for use in evaluation of obstetrical services in West Virginia.

Materials and methods

West Virginia Vital Statistics' annual reports and *"Perinatal Mortality in West Virginia,"* a Wyeth award-winning project in 1978, were used to obtain statistical data for comparison.

In addition, physicians with current medical licenses from the West Virginia Board of Medicine were surveyed by mail. These individuals are identified as gynecologists (GYN), obstetricians (OBS), obstetrician-gynecologists (OBG), maternal fetal medicine (MFM), and family or general practitioners (FP,GP) in this study.

As a final check, hospitals with obstetrical services were queried by FAX survey to provide a list of all physicians currently providing obstetrical services at their institutions.

Population

Between 1980 and 1990, West Virginia population declined by 156,157 residents – or 8 percent of the population. Only nine of the 55 counties showed population increases led by the Eastern Panhandle counties of Berkeley and Jefferson.

The outward migration during the decade totaled 208,781 residents or 10.7 percent of the population. Major population decline occurred in all ages under 25 years of age (179,198), but was primarily impacted by the group ranging from 15-24 years of age with a decline of 84,670 residents. West Virginia population statistics indicate a declining population with major increases occurring only in the Eastern Panhandle. The population is also aging.

Birth and fertility rates

Births to state residents have declined progressively from a maximum of 55,601 in 1947 (Table 1). Between the study dates of 1977 and 1991, that decline was 8,731 births or a 28.6 percent decrease.

Since 1980, the West Virginia birth rate (births per 1,000 population) has been consistently below national rates. The fertility rate (births per 1,000 women) for ages 15-44 is 56 percent, which is also significantly lower than the U.S. rate of 67.2 percent. In the 15-19 age group, the West Virginia rate of 57.5 percent is higher than the U.S. rate of 53.6 percent.

Birth and fertility rates are additional evidence for the aging of West Virginia's population. Other reasons are more speculative because of a lack of data. The increased fertility rates in teenagers with early completion of families, coupled with high sterilization rates in West Virginia, may also help to explain the reduced birth rate.

Facilities

In 1978, 65 hospitals reported births, while only 34 institutions listed births in 1991. Ten hospitals not counted had 10 or less deliveries, all occurring as emergencies. Two birthing centers reported a total of 81 births. Table 2 lists births for 1991 by institution in declining order, with comparison values for 1978 and calculated differences. Table 3 depicts cities where two institutions offer

Table 1. Births to State Residents

Year	*Live Births*	*Birth Rate*
1950	50,850	25.4
1960	39,696	21.3
1970	30,194	17.3
1980	29,438	15.1
1990	22,582	12.6
1991	21,730	n.a.*

n.a.* not available

Table 2. 1991 and 1978 Births by Hospital

Hospital	*1991*	*1978*	*Difference*
Charleston Area Medical Center	3,697	4,456	-759
Cabell Huntington Hospital	2,707	2,567	+140
Raleigh General Hospital	1,629	1,558	+ 71
Wheeling Hospital	1,476	1,124	+352
West Virginia University	1,177	928	+249
United Hospital Center	1,100	1,099	+ 1
King's Daughter's Hospital	956	606	+350
St. Joseph Hospital - Parkersburg	831	1,169	-338
Logan General	788	706	+ 82
Bluefield Community	756	1,192	-436
Fairmont General	694	933	-239
Princeton Community	656	724	- 68
Camden-Clark Memorial Hospital	629	866	-237
Monongalia General	585	1,001	-416
Davis Memorial	585	331	+254
Greenbrier Valley	506	323	+183
Ohio Valley General	444	1,358	-914
Herbert J. Thomas Hospital	401	724	-323
Weirton Medical	378	350	+ 28
St. Joseph's Hospital - Buckhannon	335	380	- 45
Welch Emergency	324	337	- 13
Grant Memorial Hospital	323	104	+219
Pleasant Valley Hospital	295	436	-141
St. Mary's Hospital	292	571	-279
Summersville Memorial	266	302	- 36
Wetzel County Hospital	259	228	+ 31
Reynolds Memorial	231	247	- 16
Stonewall Jackson Memorial	221	258	- 37
Williamson Memorial	214	213	+ 1
Jefferson Memorial	189	355	-166
Preston Memorial Hospital	186	79	+107
Roane General	159	179	- 20
Calhoun General	74	189	-115
Jackson General	44	214	-170
Summers County Hospital	8	244	-236
Webster County Memorial	2	132	-130
Broaddus Hospital*		128	
Sacred Heart Hospital*		150	
Beckley Hospital		1	
Grafton City Hospital		99	
Boone Memorial		142	
Beckley Appalachian Regional		890	
Man Memorial Appalachian Regional		199	
Memorial General - Rand		378	
Montgomery General		319	
Guyan Valley		164	
Wyoming General Hospital		116	
McClellen Clinic		115	
Sistersville General Hospital		85	
Dr. Guy's Clinic		73	
Guthrie Memorial		48	
Tucker County Hospital		39	
Morgan County War Memorial		32	
Pocahontas Memorial Hospital		31	
Greenbrier County Clinic		21	
Hampshire Memorial		15	
Holden Hospital		13	
Stevens Clinic		6	
Elizabeth Coplin Memorial		3	
City Hospital		1	
Huntington State Hospital		1	
Oak Hill Hospital		1	
CAMC - General Division		1	
Doctors Memorial		1	
McDowell County Clinic		1	

*stopped delivery service in 1990

delivery services, and Table 4 shows hospitals with less than 200 deliveries/year. In these areas, a combination of services where duplication exists and elimination of services with less than 200 deliveries per year would probably facilitate efficiency and quality of services. Federal law concerning disproportionate share funds designed for efficiency and service maintenance, essentially prohibits discontinuation or combination of services because of financial constraints, thus working at odds with attempts to consolidate and produce efficient quality services. In the areas with less than 200 deliveries/year, most residents already seek delivery services elsewhere, an indication that discontinuation would not work a hardship on local residents.

The map in Figure 1 shows overlapping hospital cachement areas, as well as regions in West Virginia not within a 30-mile radius of a hospital providing delivery services. The estimated number of deliveries in 1989 from these geographic areas is 100 births. In most areas, hospitals cachement areas overlap, thus giving patients several choices for obstetrical services.

Analysis of inward and outward migration for obstetrical services indicated that 1,932 West Virginians sought obstetrical services outside the state in 1989, and that 2,970 women from other states migrated into the state for services that year. Figure 2 displays counties showing outward migration and Figure 3 shows inward migration. In general, inward migration occurred because of the major border population centers of Huntington, Parkersburg, Wheeling and Bluefield. Outward migration occurs primarily where population centers or services in contiguous states are in close proximity or are evaluated as superior, for example, counties in the Eastern Panhandle. Figure 4 shows counties without hospital-based delivery services and numbers indicate resident births.

Health indicators

Fetal mortality rate, neonatal mortality rate, perinatal mortality, and infant mortality rate are health indicators commonly used to evaluate obstetrical care.

The fetal mortality rate is expressed per 1,000 total births and represents

Table 3. Cities with Duplicated Obstetrical Services

	1990	*1978*	*Difference < >1990-78*	*Total City Difference*
Charleston				
CAMC	3,697	4,456	-759	
H.J. Thomas	401	724	-323	-1,082
Huntington				
Cabell Huntington	2,707	2,567	+140	
St. Mary's	292	571	-279	-139
Wheeling				
Wheeling Hospital	1,476	1,124	+352	
Ohio Valley	444	1,358	-914	-562
Parkersburg				
Camden Clark	629	866	-237	
St. Joseph's	831	1,119	-288	-525
Morgantown				
University	1,177	928	+249	
Monongalia General	585	1,001	-416	-167
Princeton/Bluefield				
Bluefield	756	1,192	-436	
Princeton	656	724	- 68	-504
	13,651	16,630	-2,979	-2,979

Table 4. Hospitals with Less than 200 Deliveries to County Residents per Year (1990)

Name	*County*	*Deliveries To County Residents*	*Residents Delivering Out Of County*
Broaddus* (187)	Barbour	114	100
Calhoun General (34)	Calhoun	24	63
Jackson General (96)	Jackson	83	218
Preston County (163)	Preston	153	156
Reynolds Memorial (164)	Marshall	115	332
Roane (161)	Roane	104	86
Williamson Memorial (184)	Mingo	108	332

*stopped delivery service in 1991
( ) Number of deliveries

the birth of a fetus with no evidence of life which weighs more than 500 grams, or measures greater than 25 centimeters in length, or is greater than 20 weeks gestational age. In 1978, the fetal mortality rate was 11.2/1,000 births (U.S. rate 9.7/1,000). By 1991, this rate had decreased to 7.3/1,000 births; a decline of 34 percent. The last available U.S. figure for fetal mortality was 7.5/1,000 births.

Neonatal death is defined as the death of a live fetus which is greater than 20 weeks gestational age, weighs more than 500 grams, or has a length greater than 25 centimeters through the first 28 days of life. The associated mortality rate is expressed per 1,000 live births. In 1978, the neonatal mortality rate in West Virginia was 10.2/1,000 live births. By 1991, the rate had decreased to 5.0/1,000 live births; a decrease of 52 percent. National rates were 5.7 in 1990, which is the last year of available figures.

Perinatal mortality is the combination of fetal death and neonatal deaths expressed per 1,000 births and this figure totaled 21.9 in 1978, and 10.7 in 1991. In addition, infant mortality rates are the deaths of infants under one year of age, thus including neonatal and post-neonatal deaths. The rate in West Virginia in 1978 was 15.1/1,000, and in 1991 was 8.1/1,000. The decline in post-neonatal mortality between 1978 (4.9) and 1991 (3.0) was 39 percent.

Table 5 shows comparison of these rates with U.S. rates and clearly depicts significant improvement in West Virginia.

Providers

A total of 156 physicians with the specialty identifiers of OBG (obstetrics and gynecology), GYN (gynecology), OBS (obstetrical), and MFM (maternal fetal medicine) were identified from the current medical licensing board files. Of this figure, 18 were identified as GYN, 124 as OBG, 13 as OBS, and 1 as MFM. Each physician was surveyed by mail or by telephone to determine practice status and other variables displayed in the survey. General practitioners or family practitioners performing obstetrical services were identified by direct questions on the survey and these were then surveyed or contacted in a similar manner.

Demographics regarding age showed that 15 of 153 physicians identified as either OBG, OBS, MFM, or GYN were 66 years of age or older (range 66-78), and several had expired (4). Thirteen of those over 65 were listed in the Medical Licensing Board data as OBG; and of these, only three were actually providing obstetrical services. Thus, use of raw data from the Medical Licensing Board is inaccurate and out-of-date. No method exists to delete deceased physicians until time of the next biennial registration, and the designated specialty category does not always correctly imply the practice limitation of the physician correctly.

For this reason, hospitals providing delivery services were sent a questionnaire by FAX to request names of physicians currently providing delivery services. This mechanism added 44 physicians not previously identified. From this new total of 181 physicians, 136 obstetricians and gynecologists, and 45 family or general physicians, were identified as providing obstetrical delivery services. Of this total, though, 54 identified from the Medical Licensing Board data as OBG, GYN, OBS or MFM were not currently practicing obstetrics.

Table 6 shows the number of physicians delivering obstetrical services in the counties where those services are available. The ratio of physicians per number of deliveries is shown in the last column. If 200 deliveries per physician per year is accepted as ideal, only Berkeley, Logan and Mercer exceed the ideal, while many are well below this level. Residents, physicians in training, and general surgeons providing only Caesarean section services are not included in these figures.

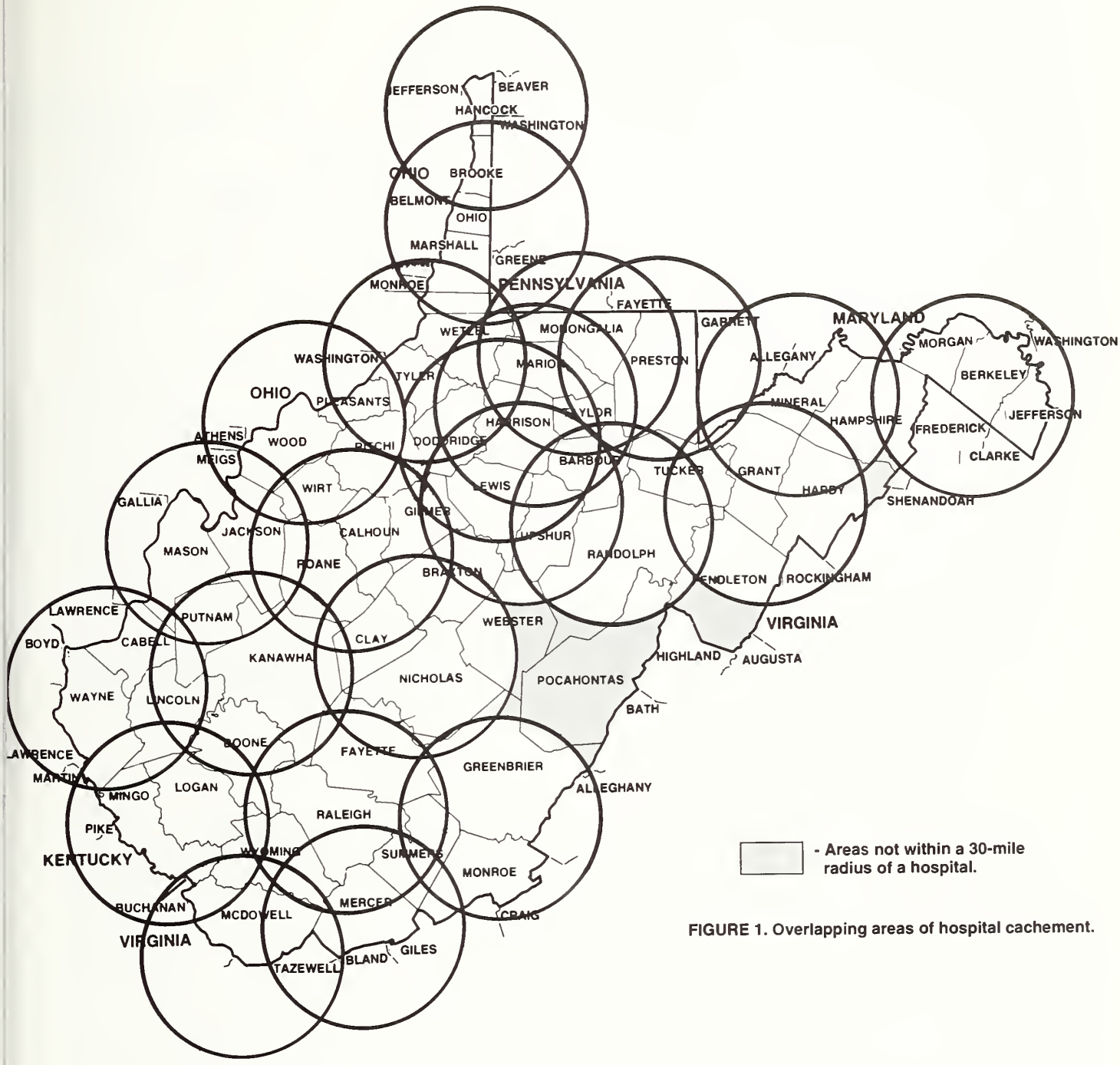


FIGURE 1. Overlapping areas of hospital cachement.

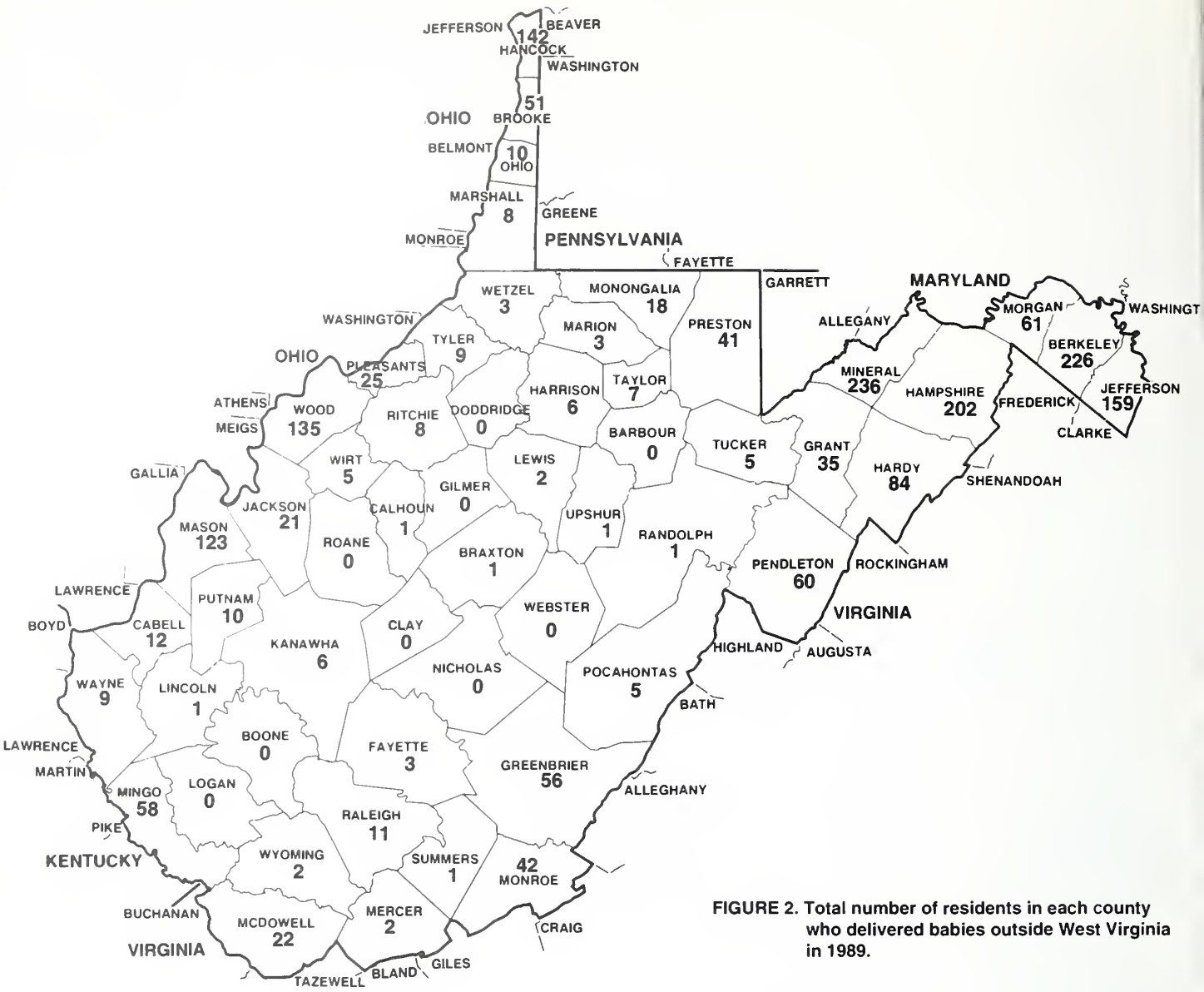


FIGURE 2. Total number of residents in each county who delivered babies outside West Virginia in 1989.

Prenatal care

Table 7 shows prenatal care access by trimester for the years 1986-1990. Access shows a small but definite increase over the past several years, but analysis by county is difficult. It is possible, though, to point to deficiencies in some counties; i.e., Logan, where only 54.5 percent of patients were seen in the first trimester, but 36.6 percent were seen in the second, for a total of 91 percent.

Careful review of this table regarding vital statistics for West Virginia reveals unusual findings. For example, prenatal care for 8.2 percent or 210 patients in Kanawha County was not recorded. One would expect far better figures in Kanawha County since it is primarily an urban county, but only 61.9 percent of patients had prenatal care in the first trimester.

Table 8 compares West Virginia statistics with those of bordering states. Using only percentages, results may cause the observer to overlook the magnitude of the problem since "no prenatal care" percentages are essentially the same in all states, yet Pennsylvania has 10 times the patients with no prenatal care (3,079), as does West Virginia (294).

Several reasons for West Virginia's reduced first trimester access may exist. Recordkeeping sources may not be accurate or may be delinquent; transfer records may be unobtainable; or the high return rate of patients to West Virginia to access liberal welfare benefits may explain the difference. The Vital Statistics figures are two years out of date and do not reflect the effect of the Medicaid Enhancement Tax which began in January of 1991, and increases the payments to providers for Medicaid patients. Analysis of 450 patients currently receiving care, including those from four health department clinics, indicates that 84 percent were seen in the first trimester and 99 percent were seen by the end of the

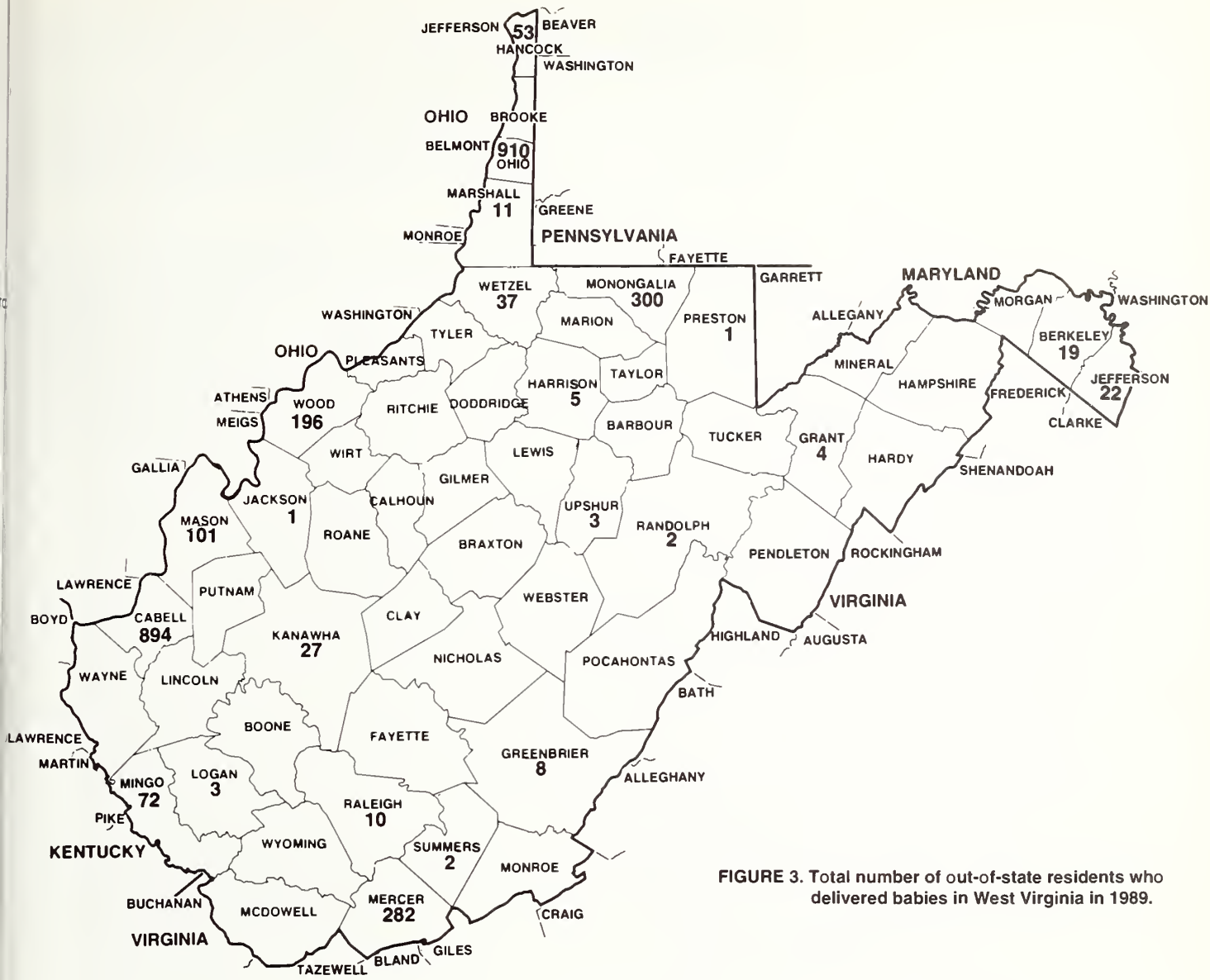


FIGURE 3. Total number of out-of-state residents who delivered babies in West Virginia in 1989.

second trimester. More often than not, if questioned, patients relate social rather than medical reasons for delayed prenatal care.

Opinions

Twenty-three physicians indicated in the survey that they had stopped practicing obstetrics and of this number, 20 mentioned too much stress and fear of litigation as their primary reasons. In addition, 28 had curtailed their obstetrical practice for reasons such as, "less high-risk patients," and "no HEC, BCBS or Medicaid." It was also important to note that 28 physicians indicated plans to curtail obstetrical practice in the near future because of difficulty recruiting, liability, poor reimbursements, hassle and increased stress!

When asked in the survey about licensing lay midwives, 90 percent of the physicians stated they were opposed to this possibility. Those supporting the licensure of lay midwives were almost exclusively limited to academic centers, and they generally qualified their approval with restrictions of certification and supervisory arrangements.

Discussion

Data is not readily available from any single source to adequately define the specialities and numbers of physicians delivering obstetrical services. The West Virginia Medical Licensing Board data defines specialty codes based on standard abbreviations of OBG, OBS, GYN, and MFM, but are not definitive when compared to physician activity. In addition, the Board records do not record deaths, address changes, or practice changes, except at biennial registrations. Thus, with the Board records listing 155 physicians in these categories, four had expired, seven had moved out of state, three had retired, and several were residents in training.

Physicians who had given up obstetrics to practice only gynecology

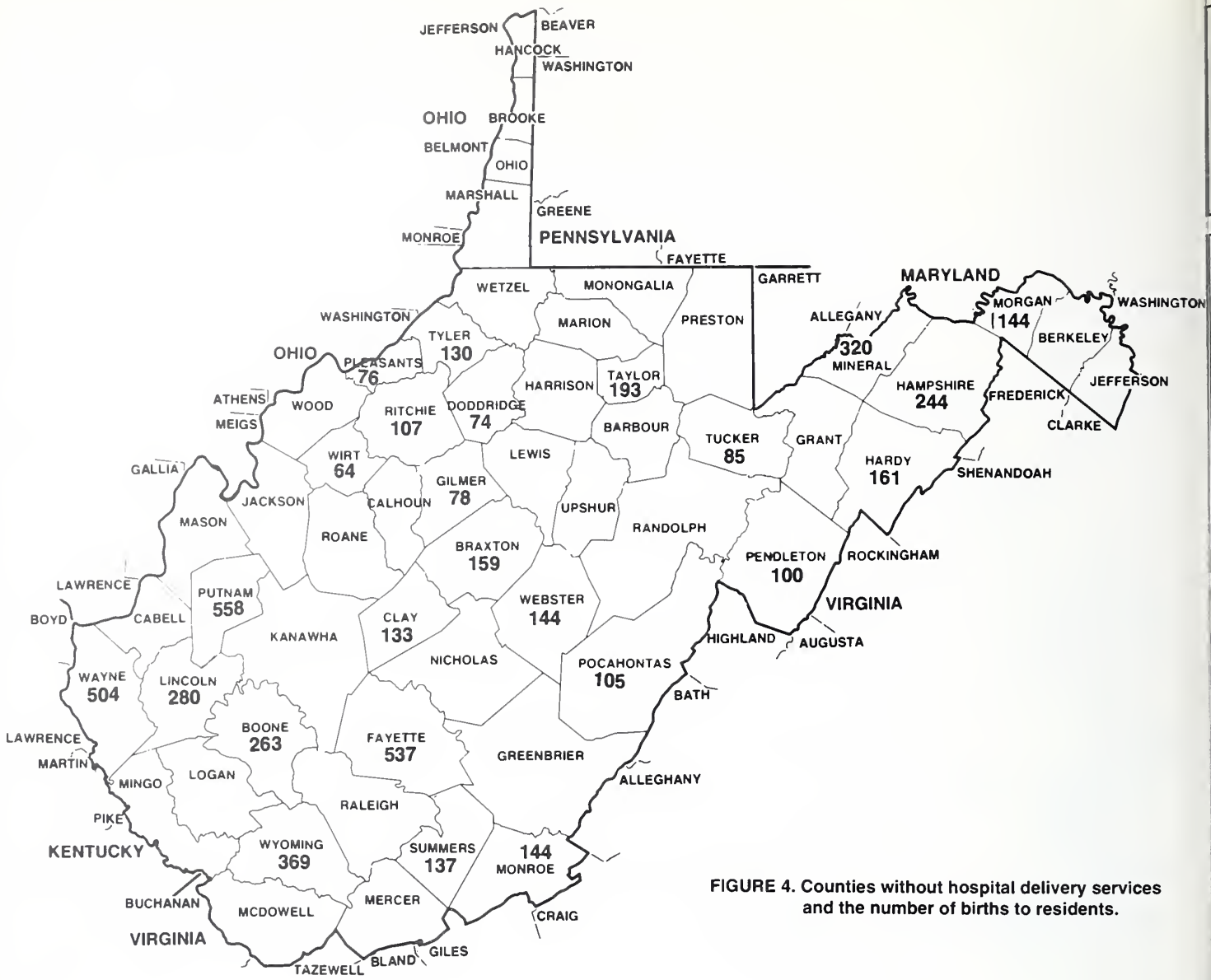


FIGURE 4. Counties without hospital delivery services and the number of births to residents.

were often listed by the Medical Licensing Board as OBG. There was also no record of family practitioners or general practice physicians doing obstetrics in the Board's information. Doctors of osteopathy are covered by another board whose data base is equally weak. Other mid-level providers are just as difficult to access regarding activity and numbers. Dacey at West Virginia University did a study for the Perinatal Task Force using birth certificate signatures to determine providers and their locations. While this was an excellent study, it is retrospective and requires significant work to obtain, in addition to the fact that it is at least 12, (and probably more), months out of date.

In the technological era in which we live, one would assume that data of this sort should be reliable and almost instantaneously available. Unfortunately, it is not, and health care planning will continue to suffer as long as the data is of poor quality. A combination of all health care provider boards would facilitate data collection. But, without careful definition of the data base and annualized collection, data will remain less than adequate for planning.

The provision of obstetrical services as measured by health indicators compares very favorably with national statistics. Fetal death rates, neonatal death rates, perinatal mortality rates and infant mortality rates have all displayed significant declines, and all are equal to or slightly better than national rates. It must be understood that these rates are approaching a minimum obtainable rate. What that rate is and how close we are to it, however, is unknown at the present time. The decline in all of these rates appears to be related to advances such as ultrasound, fetal monitoring, regionalization of neonatal intensive care, consolidation of obstetrical services, and the development of neonatal intensive care services.

Based on current volume indicators, the number of providers appears

Table 5. Health Indicators

	1978	1991	Decline Percentage
Fetal mortality rate	11.2 (9.7)	7.3 (7.5)	34%
Neonatal death rate	10.2	5.0 (5.7)	52%
Perinatal death rate	21.4	12.3 (13.2)	43%
Infant mortality rate	4.9	3.0	34%

Table 6. Physicians Providing Delivery Services

Counties with Delivery Services	*Number of Hospitals*	*Deliveries*	*Physicians OB/GYN*	*FP*	*Ratio of Physicians/ Deliveries*
Berkeley	1	956	2	0	1:478
Brooke	1	278	4	1	1:71
Cabell *(F)	2	2,999	20	7(19)	1:111
Calhoun	1	74	0	1	1:74
Grant	1	323	3	0	1:107
Greenbrier	1	506	3	0	1:168
Harrison *(F)	1	1,100	4	2(18)	1:183
Jackson	1	44	0	1	1:44
Jefferson	1	189	1	4	1:38
Kanawha *(FO)	2	4,098	21(12)	7(12)	1:146
Lewis	1	221	0	2	1:110
Logan	1	778	3	0	1:259
McDowell	1	328	3	1	1:82
Marion	1	694	4	0	1:174
Marshall	1	231	2	1	1:77
Mason	1	295	3	0	1:98
Mercer	2	1,412	5	1	1:235
Mingo	1	214	4	0	1:54
Monongalia *(FO)	2	1,762	17(8)	5(18)	1:80
Nicholas	1	276	1	4	1:55
Ohio *CO	2	1,920	9(2)	0	1:213
Preston	1	186	0	2	1:93
Raleigh	1	1,629	13	0	1:125
Randolph	1	585	3	1	1:194
Roane	1	159	0	2	1:80
Upshur	1	337	1	2	1:112
Wetzel	1	259	1	1	1:130
Wood	1	1,460	9	0	1:162
		23,313	136	45	1:129

*Counties with hospitals with residency training programs
C OB/GYN program is closing
F Family practice residency
O OB/GYN practice residency
( ) Residency positions

adequate, and the distribution within reasonable parameters, except as noted. The problem in Berkeley County is both acute and surprising. Widely regarded as one of the most attractive areas in the state and one that is growing, only two physician providers exist. Services are available to all West Virginians within a 30-mile driving distance, except for a small area along the eastern border.

West Virginians frequently seek out-of-state obstetrical services in border counties. In most instances, local care is available; but major out-of-state centers exist in close proximity and services, i.e. anesthesia, are frequently better. Inward migration of women from other states occurs for similar geographic reasons, and in slightly greater numbers. In fact, over 15 percent of in-state births occur to out-of-state residents, while 10 percent of West Virginia resident births occur out of state. These observations are critical in state planning for health care and indicate the complexity of single state planning for health care coverage.

Duplication of services was addressed in the 1978 study. A significant reduction in hospitals providing delivery services occurred. Despite the increased efficiency, there remain several areas of unnecessary duplication. In addition, the development of "birthing centers" threatens the advances. Guidelines for basic care were established in *"Perinatal Guidelines"* which is published by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. It is doubtful that hospitals with less than 200 deliveries per year or birthing centers in remote areas can meet these guidelines even for Level I care.

While the factors discussed in the previous paragraph only marginally

Table 7. Prenatal Care Access by Trimester (%)

	1st	2nd	3rd	No-prenatal care
1986	68.7	21.9	5.5	1.2
1987	68.5	21.9	5.7	1.3
1988	69.4	22.3	4.7	1.0
1990	71.3	20.3	4.2	1.3
1993*	84.0	15.0		

*Survey from southern West Virginia county.

Table 8. Prenatal Care in West Virginia Compared by Trimester to Four Other States

	Deliveries	1st	2nd	3rd	Unknown	No Care	#Patients Without Care
West Virginia	22,582	71.3	20.3	4.2	2.9	1.3	294
Kentucky	54,041	77.2	17.4	3.3	.7	1.4	756
Virginia	32,550	79.5	15.4	3.1	.6	1.5	489
Ohio	166,686	81.0	14.0	3.0	.6	1.4	2,333
Pennsylvania	171,053	78.1	14.7	3.5	1.9	1.8	3,079

address the quality of services, quality can only be addressed by chart review. This is best performed at the local hospital unit if specific guidelines are established. These guidelines exist in the *Standards for Obstetric-Gynecologic Services*, which is published by the American College of Obstetricians and Gynecologists and in *Perinatal Guidelines*. These guidelines define facilities, procedures, time limits, etc., as established national standards for care. Small units must critically review these requirements and their ability to satisfy minimal standards. Continued consolidation of obstetrical services is needed. As in the past, this must be done with a molding of medical, economic, and consumer concerns so that a technically sophisticated, but sensitive and humanistic approach to care, is available to all. A system driven to fragmentation by the failure of different special interest groups to work for a common goal of improved maternal and fetal mortality and morbidity, will bankrupt the system financially and negate or reverse the gains made so painfully in the past.

The state evaluation of obstetrical services tends to view occurrences by counties and regions. While historically and politically counties have reasons for existing, patient flow for obstetrical services does not always follow county lines. Twenty-three counties are without delivery services and counties are frequently grouped into regions. Fayette County is grouped in Region 4, although 80+ percent of births to county residents occur in Raleigh County, which is not a Region 4 county.

More appropriate grouping would be cachement areas of hospitals providing delivery services. In fact, roads probably influence choice in a major fashion, as do availability of nearby out-of-state medical centers in those areas where outward migration of West Virginia residents for services is maximum. In areas were outward or inward migration of patients occurs, cooperation, data collection and planning with adjacent counties or states without regard to county boundaries are probably the best mechanisms.

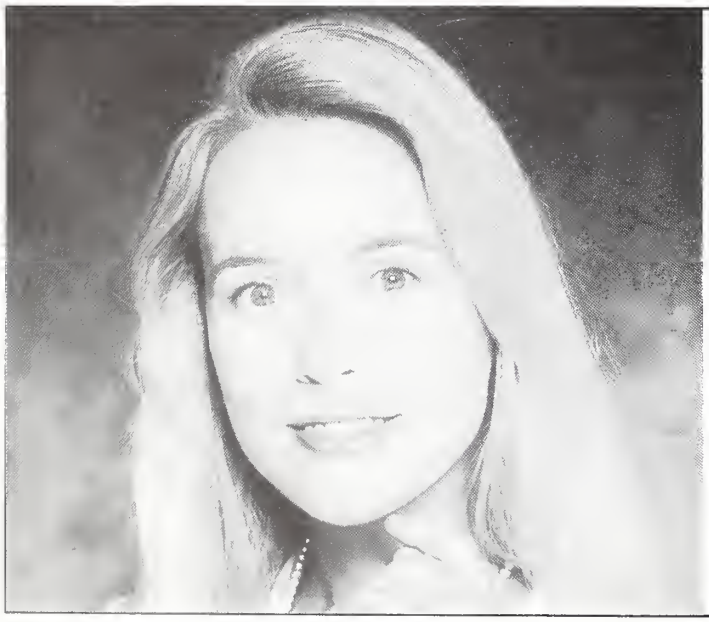
Conclusions

This study has resulted in the following conclusions:

1. Satisfactory data bases for provider and obstetrical care do not exist.
2. An adequate number of obstetrical providers exists in West Virginia. There is mild distributional inequity of providers in Berkeley, Mercer and Logan counties.
3. Health indicators show obstetrical services are equal to or slightly better than national averages.
4. Access to care has shown dramatic improvement as measured by current data, and is directly related to the Medicaid Enhancement Program.

References

1. Pearson RJC, Whitler RD. Fewer delivery doctors. WVa Med J 1989 Aug;85:334.
2. Pulliam RP. Perinatal mortality in West Virginia. Wyeth Award 1978.
3. Birth flow by county and hospital, West Virginia, 1989.
4. West Virginia Provisional 1991 Vital Statistics.
5. 1990 West Virginia Vital Statistics.
6. Dacey Ann. Identification of obstetrical providers in West Virginia in 1991.



Now there's a safer and more effective treatment for red vascular birthmarks

Fast . . . F.D.A. Approved . . . and near your hometown.

With our new Candela Vascular Lesion Laser, we can now treat birthmarks like Port Wine Stains and other red blemishes including small facial veins . . . effectively and with minimum discomfort.

Call for a consultation appointment:

1-800-628-6748

LAWRENCE W. TARRANT, M.D.

Certified By: American College of Surgeons
American Board of Plastic Surgery
Fellow of the American College of Surgeons
Fellow of the Royal College of Surgeons (Canada)

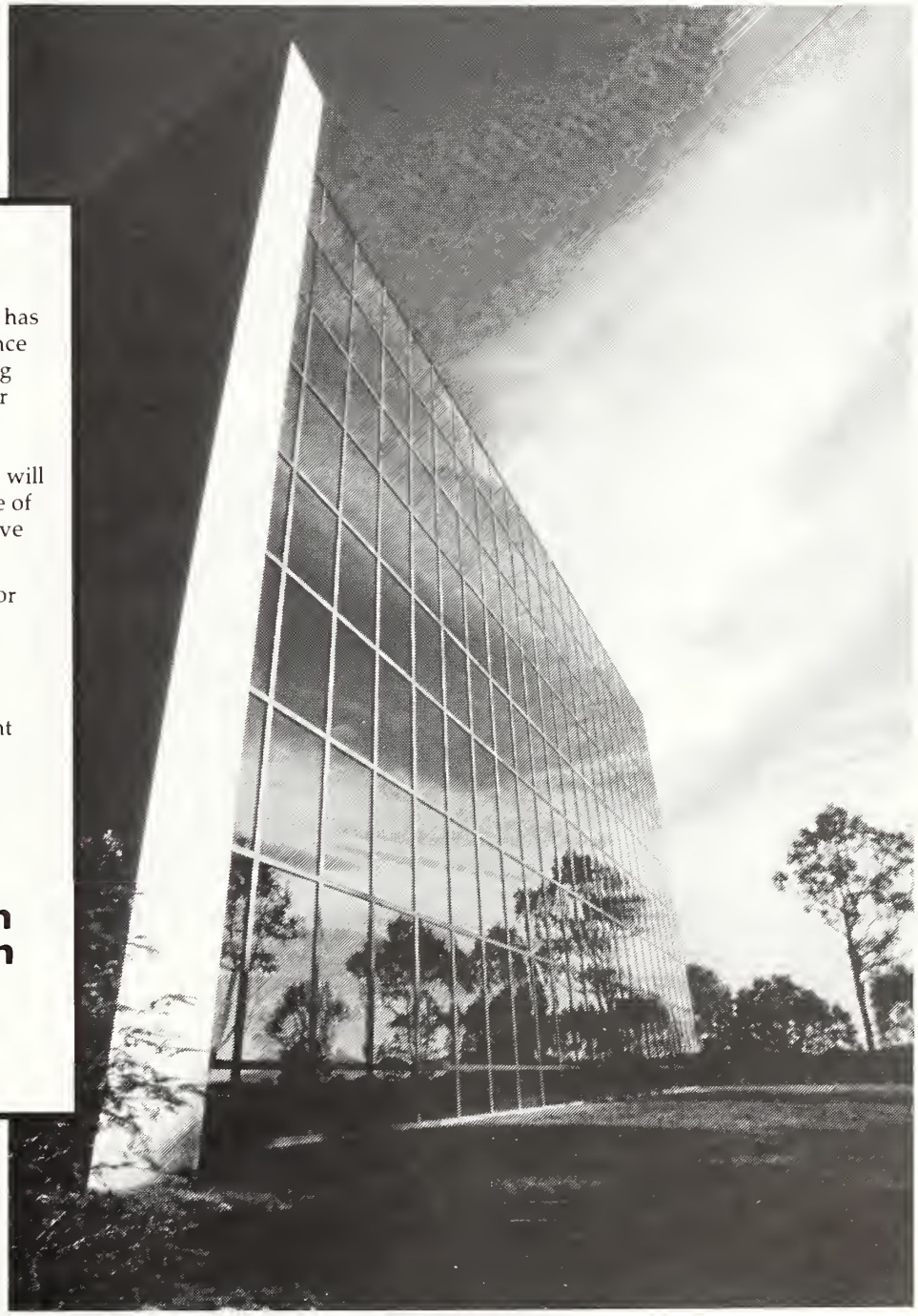
Service is the cornerstone of our business.

Upon a foundation of experience and professionalism, McDonough Caperton has built a regional insurance brokerage firm assisting clients nationwide. Our mission is to provide a distinctive service of outstanding value that will remain the cornerstone of our business as we move forward.

- Comprehensive Major Medical
- Professional Office Overhead
- Term Life
- Medicare Supplement
- Disability Income
- Hospital Indemnity

Call Us. 1-800-344-5139
Extension 708

McDonough Caperton Insurance Group



Corporate Headquarters One Hillcrest Drive, East, P.O. Box 1551, Charleston, WV 25326-1551, Telephone: (304) 346-0611 Fax: (304) 347-0697
With Offices Located in: Florida, Georgia, Kentucky, Ohio, Pennsylvania, Virginia, West Virginia and Bermuda

WESPAC

West Virginia State Medical Association's
Political Action Committee

With so many challenges facing organized medicine, it is imperative that we have support in the Legislature. The need for political action has never been greater!

Write your personal check to WESPAC today and help us strengthen our role in the legislative process.

$50 - Regular **$100 - Sustainer**
$150 - Extra Miler

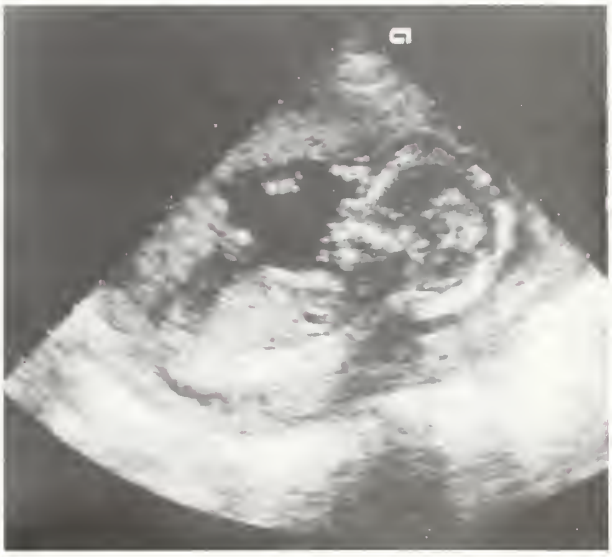
Mail your personal check to:

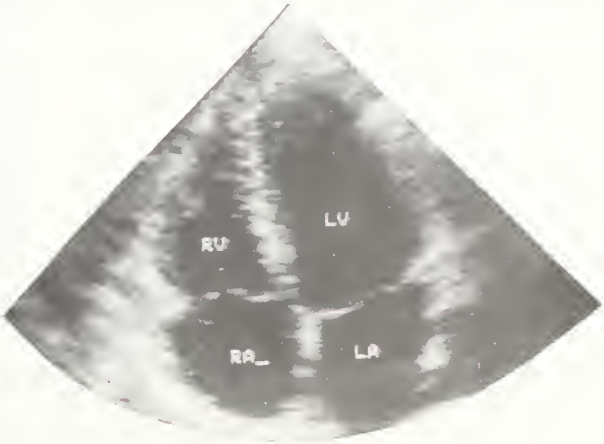
WESPAC
P.O. Box 4106
Charleston, WV 25364

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time





Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

Double cheek-cervical rotation flap for repair of facial defects

ROMEO Y. LIM, M.D., F.A.C.S.
Chief of Surgery, The Eye and Ear Clinic of Charleston, Inc.; and Clinical Professor, Otolaryngology/Head and Neck Surgery and General Surgery, WVU Health Sciences Center, Charleston Division, and Charleston Area Medical Center, Charleston

SAMUEL A. STRICKLAND, M.D.
Chief of Ophthalmology, The Eye and Ear Clinic of Charleston, Inc.; and Clinical Professor, Ophthalmology, WVU Health Sciences Center, Charleston Division, and Charleston Area Medical Center, Charleston

JESSICA W. LIM, M.D.
Second-Year Resident, Department of Surgery, NYU Bellevue Medical Center, New York City

Abstract

Repair of extensive facial defects due to cancer surgery or trauma is a challenge to restore form, function, and facade. This article studies the advantages of using the double cheek-cervical rotation flap for immediate reconstruction of 10 patients with huge facial defects.

Introduction

Extensive defects from surgery of malignant lesions or severe injury of the face require immediate reconstruction to achieve cure, function, and cosmetic result. An ideal tissue flap for coverage of such defects should be accessible, abundant, reliable, simple, instant, viable, color-matched, and it should also integrate with facial animation and avoid scars. The double cheek-cervical tissue flap fulfills all of these criteria.

Various flaps for repair of facial defects were reported by Conley (1) utilizing regional flaps and Wurster and Ossoff (2) using the sternocleidomastoid myocutaneous flap. Becker (3), Garrett and colleagues (4) preferred the cervicopectoral flap to cover facial and upper cervical defects following cancer surgery. Use of the cheek-cervical rotation flap was described by Patterson and colleagues (5) in 1984 for repair of temporozygomatic defects ensuing from trauma or surgery. Crow (6) in 1976 and Kaplan et al (7) in 1978 noted the versatility of the laterally-based cervicofacial flap for resurfacing large cheek defects. In 1991, Cook and colleagues (8) presented their experiences on the efficacy of the inferiorly-based cervical facial rotation flap for repair of midface defects.

This paper reports our experiences with the double cheek-cervical rotation flap for reconstruction of enormous facial defects following cancer surgery and trauma.

Materials and methods

Between 1987 and 1991, 10 patients underwent reconstruction of facial defects using a double cheek-cervical rotation flap following cancer resection or trauma. These patients included seven men and three women whose ages ranged from 58 to 84 years. There were four patients with squamous cell carcinoma, two with basal cell carcinoma, two with verrucous carcinoma, and two with trauma of the face.

The defects measured 30 cm. to 60 cm.^{2} and seven involved the midface, two were upper lips and one involved the cheek area. One of the midface defects also affected the entire lower lid.

Technique

Under general endotracheal anesthesia following cancer resection or debridement, the facial defect was measured and the posteriorly-based cheek rotation flap was outlined, elevated along the subcutaneous plane superficial to the facial muscles and mobilized to cover the defect. The flap along the lower eyelid was thinned out and anchored superiorly to the periosteum or temporal fascia to prevent the dragging effect on the lower lid that can result in ectropion. A buccal or septal mucosal graft with septal cartilage was incorporated to provide a posterior eyelid lamella for reconstruction of the lower lid.

The cervical rotation flap was mobilized to reconstruct the cheek donor defect. Polyglycolic acid (Vicryl Ethicon) 4-0 sutures were used for subcutaneous closure and 5-0 prolene sutures or staples for the skin closure over penrose drains. Light pressure dressings were applied.

Intravenous broad spectrum antibiotics were administered intraoperatively in all cases and all patients were kept overnight. The follow-up period ranged from six months to four years and there was no postoperative infection or facial paralysis. Late flap necrosis occurred in one patient as a result of tumor recurrence. Severe ectropion was observed in a patient with squamous cell carcinoma of the infraorbital area that had been excised twice before re-excision and double cheek-cervical rotation flap reconstruction. Overall, the functional and cosmetic results have been excellent.

Figure 1. Basosquamous carcinoma involving the lower eyelid and midface.

Figure 2. Surgical defects of the lower eyelid, bulbar conjunctiva and midface.

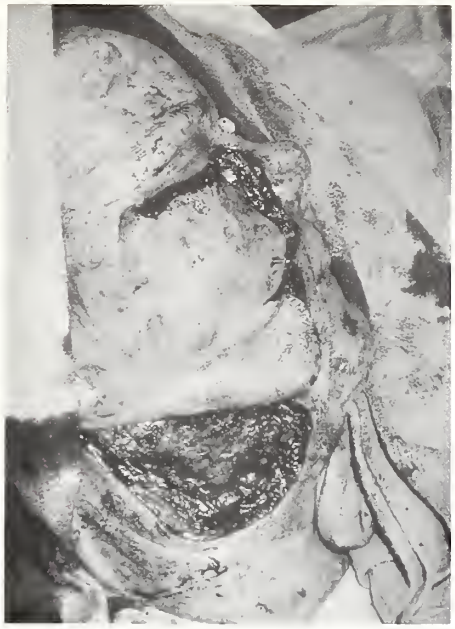


Figure 4. Reconstruction of lower eyelid and bulbar conjunctiva.

Figure 3. Mobilization of double cheek-cervical rotation flap.

Figure 5. Completion of double cheek-cervical rotation flap repair.

Case Study

A 53-year-old Caucasian woman was examined for an extensive skin lesion on the entire right lower eyelid and infraorbital area of three years' duration. The tumor measured 4.5 cm. x 4 cm. and was rodent type, involving the entire lower eyelid, lateral and medial canthal structures (with unimpaired eye mobility), the entire infraorbital area and the nasoalar groove (Figure 1). The regional nodes were not palpable. The clinical impression was basosquamous carcinoma. CT scan of the orbits and paranasal sinuses disclosed possible extension to the ipsilateral orbital floor and anterior ethmoid sinus.

Treatment

Under general endotracheal anesthesia, the tumor was extirpated using the contact Nd:YAG laser (9) to include the entire lower eyelid, medial and canthal areas, infraorbital area, nasolacrimal duct and anterior ethmoid sinus. Slivers of bone of the orbital floor and anterior maxilla were chiseled. The (35 cm.^{2}) surgical defect shown in Figure 2 was reconstructed with a double cheek-cervical rotation flap and a full thickness buccal mucosa for the inferior conjunctival cul-de-sac and bulbar conjunctiva (Figures 3,4,5). Intravenous broad spectrum antibiotics were administered intraoperatively.

Postoperative course and results

The drains were removed and the patient discharged on the third postoperative day. Complete healing was observed three weeks postoperatively. Histological report confirmed the clinical diagnosis of basosquamous carcinoma and the frozen sections showed clear margins. A two-year follow-up revealed no recurrence with excellent facial motion, eye and cosmetic function (Figures 6,7).

Discussion

Extensive facial defects due to cancer surgery or trauma can cause physical, functional, as well as psychological afflictions. Immediate reconstruction is mandated to restore form, function and expression. For repair of extensive facial defects, the double cheek-cervical rotation flap provides tissue abundance (60 cm.^{2}), tissue color, texture match and tissue proximity. The flap can be placed along skin folds and creases of the face to minimize obvious scars. Since the majority of patients with facial cancer are elderly, skin laxity offers ample size to fit most facial defects.

Scars created by the lines of closure should follow natural creases of the face such as the nasolabial, nasoalar, preauricular and infraorbital areas. When operating on facial tumors with suspected metastasis, elevation of this flap offers excellent exposure of the parotid and upper cervical lymph nodes for detection and simultaneous dissection (10). In cases where additional tissue is required, adjunctive skin or mucosal grafts can be used to resurface the linings of the nose, lips and conjunctiva. Tissue expansion is an option to provide extra tissue dimension. Severe flap necrosis was reported by Cook (8)

Figure 6. Well-healed scar two years after surgery.

Figure 7. Restored facial form and function two years after surgery.

and colleagues in two of four irradiated patients. Thus, its limitations may apply to irradiated patients and defects over 60 cm^2.

Summary

The double cheek-cervical rotation flap is an option to reconstruct huge facial defects. Understanding of flap viability and relaxed tension lines is important to restore form and function and to achieve cosmetic results.

Acknowledgement

The authors wish to thank Mary Jane Willis, P.A., for preparing the manuscript; Suzanne Berry and Andy Louni for tracking and taking the postoperative pictures; and Phillip R. Stevens, M.D., for referring the case illustrated.

References

1. Conley J. The use of regional flaps in head and neck surgery. Ann Otol Rhinol Laryngol 1960;69:1223-34.
2. Wurster CF, Osoff RH. Reconstructive techniques after ablative head and neck surgery. Otolaryngol Clin North Am 1985; 18:551-72.
3. Becker DW. A cervicopectoral rotation flap for cheek coverage. Plast Reconstr Surg 1978; 61:868-70.
4. Garrett WS, Giblin TR, Hoffman GW. Closure of skin defects of the face and neck by rotation and advancement or cervicopectoral flaps. Plast Reconstr Surg 1966;38:342-6.
5. Patterson HC, Anonsen C, Weymuller EA, Webster RC. The cheek-neck rotation flap for closure of temporozygomatic-cheek wounds. Arch Otolaryngol Head Neck Surg 1978;61:868-70.
6. Crow ML, Crow FJ. Resurfacing large cheek defects with rotation flaps from the neck. Plast Reconstr Surg 1976;58:196-200.
7. Kaplan I, Goldmyn RM. The versatility of the laterally based cervicofacial flaps for cheek repairs. Plast Reconstr Surg 1978;61:390.
8. Cook TA, Israel JM, et al. Cervical rotation flap for midface resurfacing. Arch Otolaryngol Head Neck Surg 1991;117:77-82.
9. Lim RY, Willis MJ. Contact Nd:YAG laser for soft tissue surgery. WVa Med J 1991;87:246-9.
10. Weisberger EL, Hanke W. Reconstruction of full thickness defects of the cheek. Arch Otolaryngol 1983;109:190-4.

New Manuscript Guidelines

All scientific manuscripts should be submitted on disc in the following languages: Wordperfect 4.2, 5.0, and 5.1; Word; Word for Windows; and WordStar. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

No more than 25 references will be published free of charge and they must be presented in the style based on the formats used by the U.S. National Library of Medicine in *"Index Medicus."*

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

The use of modern radiologic methods in identifying incidental renal cell carcinoma

STEVEN J. JUBELIRER, M.D.
Director, Cancer Care Center of Southern West Virginia, Charleston Area Medical Center, Clinical Professor of Medicine, West Virginia University, Charleston Division
MARC RUBIN, MSIII
Marshall University School of Medicine, Huntington

Abstract

The increased use of ultrasonography and computed tomography has made the incidental discovery of renal masses more common. With this factor in mind, the records of 109 patients with renal cell carcinoma diagnosed and treated at Charleston Area Medical Center (CAMC) between 1983 and 1990 were reviewed to determine how many cases were "incidentally diagnosed." Thirty-two (29 percent) of these patients had their renal cell carcinoma discovered incidentally; and of these tumors, 47 percent were Stage I and only 13 percent were Stage IV; for symptomatic patients, 22 percent were Stage I and 36 percent were Stage IV. This study also found that the classic triad of pain, hematuria and flank mass was present in only six of 109 patients (5.5 percent). Tumors found incidentally will usually be of lower pathological stage and may carry a better prognosis.

Introduction

With increased use of technological advances such as computerized tomography (CT), ultrasound, and the continued use of intravenous pyelography (IVP) as a standard diagnostic tool, renal tumors are being diagnosed as "incidental findings" with reported frequency. This study was undertaken to determine the incidence of "incidentally"-diagnosed renal cell carcinoma, and to compare the pathologic stage of these tumors to that of those suspected at the time of diagnosis. The hypothesis is that the tumors discovered "incidentally" are found at a lower stage than those tumors diagnosed as "non incidental."

Patients and methods

The hospital records, pathology reports, and tumor registry data of 109 patients with renal cell carcinoma diagnosed and treated at Charleston Area Medical Center (CAMC) between 1983 and 1990 were reviewed. The presenting signs and symptoms as well as admission urinalyses were reviewed to determine the presence or absence of the classic triad of pain, flank mass, and hematuria. The tumor stage was determined in all patients, utilizing the Robson Modification of the Flocks and Radesky Staging System (Table 1) (1).

The cases were designated as "incidental" or "non-incidental" based on whether a urologic malignancy was suspected and sought at the time of the study. The "incidental" diagnosis of renal cell carcinoma was determined by one of the following:

1. Plain film of the abdomen (KUB),
2. Barium enema,
3. Ultrasonography,
4. Arteriography,
5. Intravenous pyelography (IVP); or
6. Abdominal and spinal computed tomography (CT).

The various complaints being evaluated included diverticulitis, cholelithiasis, gynecologic disease, peripheral vascular disease (aneurysm), and spinal stenosis. A number of "incidentally"-diagnosed renal cell carcinomas were based on studies performed to determine the

Table 1. Robson Modification of the Flocks and Radesky Staging System of Renal Cell Carcinoma

Stage	*Description*
1	Tumor confined to renal parenchyma
	Tumor invading through renal capsule with Gerota's fascia intact
3A	Renal vein or inferior vena cava grossly involved
3B	Lymphatic involvement
4A	Tumor involving adjacent organs
4B	Distant metastases

Table 2: Incidentally diagnosed renal cell carcinoma according to the radiologic study utilized

Reason for study	IVP	Ultrasound	Abdominal CT Scan	Arteriography	KUB	Barium Enema
Dysuria	1		3		1	
Kidney Stones/Colic	1		1			
Anemia			2			
Back Pain (Spinal Disease)		1	1			
Fever (R/O Abcess)			1			
Cholecystitis/Cholelithiasis		4	1			
Diverticulitis						1
Pancreatitis		1				
Gynecologic Complaints		1				
Myocardial Infarction		1 (cardiac echo)				
Abdominal Aortic Aneurysm				2		
Renal Insufficiency		1				
Hypertension			3	2		
Asymptomatic (Reason Not Given)			2			
Muscle Weakness			1			
TOTALS	2	9	15	4	1	1

Table 3. Clinical features of incidental vs. non-incidental renal cell carcinomas

Parameter	Incidental N = 32	Non-incidental N = 77
Stage		
1	15 (47%)	17 (22%)
2	10 (31%)	25 (33%)
3	3 (9%)	7 (9%)
4	4 (13%)	28 (36%)
Location		
Right	15 (47%)	41 (53%)
Left	17 (53%)	36 (47%)
Sex		
Male	20 (63%)	40 (52%)
Female	12 (37%)	37 (48%)
Age (Mean)	61.5 years	62 years

presence of other urologic diseases such as recurrent urinary tract infections or kidney stones. Cases were considered "non-incidental" (symptomatic) if the tumor was discovered on IVP, ultrasound, or CT scan as part of an evaluation of hematuria, flank pain, flank or abdominal mass, suspected metastatic disease, weight loss, or fever.

Ridit analysis (2) was performed to test if the tumors discovered "incidentally" were determined to be at a lower stage than those tumors diagnosed "non-incidentally." This method was employed because the differences in severity among the consecutive stages are not equal. Using all 109 patients as a reference group to generate ridit scores, we found $Z = 2.81$ ($p = 0.005$). This score indicates that the stages at which the tumors in the incidental group were determined are significantly lower than the stages of tumors determined in the non-incidental group.

Results

A total of 109 cases (69 males, 49 females) were reviewed, of which 32 (29 percent) were diagnosed with "incidentally" found renal cell carcinoma. The mean patient age for "incidentally" and "non-incidentally" found tumors was 61.5 years and 62 years respectively. Eighty patients underwent radical nephrectomy.

Table 2 presents the diagnostic studies from which these "incidental" tumors were found. Fifteen renal cell carcinomas were found by computed tomography (47 percent), nine were by abdominal ultrasound (28 percent), four were by arteriography (13 percent) for the evaluation of hypertension or abdominal aortic aneurysm, two were (6 percent) by IVP, one was by KUB, and one was by barium enema.

Table 3 compares the clinical features (i.e. stage, sex, mean age, location, etc.) of "incidentally" and "non-incidentally"-diagnosed renal cell carcinomas. Of the 32 in the incidental group, 15 (47 percent) were Stage I and only four (13 percent) were Stage IV at the time of diagnosis. Of the 77 in the "non-incidental" group, only 17 (22 percent) were Stage I and 28 (36 percent) were Stage IV ($p. = .028$). Fifty-six (51 percent) of the 109 tumors were right-sided and 53 (49 percent) were left-sided. Of the "incidentally"-found tumors, 15 (47 percent) were right-sided and 17 (53 percent) were left-sided. Forty-one (53 percent) of the "non-incidentally"-found tumors were right-sided.

Only six of 109 (5.5 percent) of the patients presented with the triad of pain, palpable flank mass, and hematuria in this series. Their respective tumor stages were II (two patients), III (one patient), and IV (three patients).

Discussion

Since Grawitz (3) first described renal cell carcinoma in 1883, there have been many large series focused on its diagnosis. Fewer series have been reported since the routine use of computed tomography and ultrasonography. For many years, the diagnosis of renal cell carcinoma was made only when the classical triad of flank pain, hematuria, and a palpable mass was present (4). Only 5.5 percent of the patients described here presented with this classic triad, which is less than the 10-50 percent reported in the literature before the advent of CT scanning and ultrasound (3-6).

Previous studies prior to the era of CT have reported renal cell carcinoma as an "incidental" finding, or silent tumor, in 4 percent to 20 percent of the cases with criteria similar to ours (4,6,8,9,10,11). More recent studies have reported a higher incidence of "incidental" tumors. For example, Konnak and Grossman (12) reported that 48 percent of renal cell carcinomas treated between 1980 and 1984 were discovered incidentally; Sigalow and colleagues (13) noted that 47 percent of renal cell carcinomas diagnosed between 1983 and 1987 were incidental; Veda and Mihara (11) found that two out of 16 (13 percent) of the patients presenting between 1976 and 1980 had their tumor found by chance, compared with 13 of 37 (35 percent) between 1981 and 1985; Rittenhouse and Hadley (14) reported that 30 percent of their cases of renal cell carcinoma were incidental; and Thompson and Peek (15) noted that 25 percent of their cases were incidental.

The criteria used to separate patients into suspected and incidental groups are somewhat arbitrary, but individual findings or combinations of hematuria, flank pain, flank mass, weight loss, and metastatic disease are well-recognized presenting signs or symptoms of renal cell carcinoma. Any patient who underwent radiologic evaluation for these findings was included in the "non-incidental" group. Two patients in the "incidental" group had X-rays (i.e. one an ultrasound and the other an abdominal CT scan) for back pain, but this was bilateral or midline low back pain and not flank or abdominal in nature. Patients with non-specific abdominal pain or other non-specific abdominal symptoms were included in the incidental group if the study was done for the diagnostic evaluation of gallbladder disease or other non-renal problems and a renal origin of symptoms was not suspected. Although there may have been some overlap in a few patients,

this most clearly belonged to one group or the other.

Tumors discovered incidentally have a better prognosis than symptomatic tumors, most likely owing to their lower stage than tumors producing symptoms (15). As shown in Figure 1, 47 percent of those without symptoms at diagnosis had disease confined to the kidney and only 13 percent had distant metastases. By comparison, only 22 percent of those with symptoms had localized disease and 36 percent had distant metastases at presentation. Ritchie and de Kernion (16) reported that, of 3,232 histologically confirmed cases of renal cell carcinoma, 77.5 percent of those without symptoms had disease confined to the kidney compared to 43.9 percent of those with symptoms at diagnosis. Distant metastases were noted in 9.4 percent of asymptomatic and 28 percent of symptomatic patients.

Survival after nephrectomy for renal cell carcinoma is related to the anatomic extent of the disease with the presence or absence of metastases being the most important determinant. Patients with no evidence of metastases have a 90 percent, two-year survival rate compared with 20 percent for those with metastases. Five-year survival rates of up to 93 percent have been reported for tumors confined to the renal capsule (17).

Although there are sensitive diagnostic methods and an effective treatment for early-stage renal carcinoma, the relative rarity of this tumor makes screening unlikely to be cost-effective. However, for patients at highest risk (males over age 50) having an ultrasound for other reasons, a "quick look" at the kidneys may identify a tumor for which there is effective treatment.

Acknowledgement

The authors would like to thank Dr. Sandra Magnetti, Mary Blanton, M.Ed.; and Jay Zhang for reviewing this manuscript.

References

1. Flocks RH, Radesky MC. Malignant neoplasms of the kidney: an analysis of 353 patients followed five years or more. J Urol 1958;79:196-201.
2. Fleis JL. Statistical methods for rates and proportions. John Wiley and sons 1981;150-7.
3. Grawitz P. Die sogenannten lipome der niere. Virchows Arch (Pathol Anat) 1883;93:39.
4. Warren MW, Ketalis PP, Utz DC. The changing concept of hypernephroma. J Urol 1970;104:376-9.
5. Skinner DG, Colvin RB, Vermillion CD, et al. Diagnosis and management of renal cell carcinoma. J Urol 1971;28:1166-77.
6. Ochsner MG, Brannan W, Pond HS, et al. Renal cell carcinoma: review of 26 years of experience at the Ochsner Clinic. J Urol 1973; 110:643-6.
7. Kaufman JJ, Mims MM. Tumors of the kidney. In: Current Problems in Surgery. Chicago: Yearbook Medical Publishers, 1966:44.
8. Arner O, vonSohreeb T. Renal adenocarcinoma: symptoms and signs. Acta Chir Scan 1966;132:348-54.
9. Skinner DG, Vermillion CD, Colvin RB. The surgical management of renal cell carcinoma. J Urol 1972;107:705.
10. Waters WB, Ritchie JP. Aggressive surgical approach to renal cell carcinoma: review of 130 cases. J. Urol 1979;122:306.
11. Veda T, Mihara Y. Incidental detection of renal carcinoma during radiological imaging. Br J Urol 1987;59:513.
12. Konnak JW, Grossman HB. Renal cell carcinoma as an incidental finding. J Urol 1985;134:1094-6.
13. Sigalow DA, Waldbaum RS, Lowe FC. Identification of asymptomatic renal cell carcinomas utilizing modern radiographic techniques. NY State J Med 1991;91:200-2.
14. Rittenhouse JR, Hadley HR. Diagnosis of renal cell carcinoma: has the liberal use of computerized scanning increased the proportion of incidentally diagnosed renal cell carcinomas? J Urol 1988;139:211A.
15. Thompson IM, Peek M. Improvement in survival of patients with renal cell carcinoma--the role of serendipitously detected tumor. J Urol 1988; 140:487-90.
16. Ritchie AWS, Dekernion JB. Incidental renal neoplasms: incidence in Los Angeles County, treatment and prognosis. In: Schroder FH, editor. Progress and controversies in oncological urology. New York: Alan Liss Inc, II, 1988:347.
17. Selli C, Hinshaw W, Woodward BH, Paulson DF. Stratification of risk factors in renal cell carcinoma. Cancer 1983;52:899-903.

WMC Inc.

WILLIAM C MORGAN, Jr., M.D., F.A.C.S.
Otologist
Diplomate, American Board of Otolaryngology
OTOLOGY: DISEASES & SURGERY OF THE EAR

Sheri L. Jeffries
Audiologist

304-345-7100

Complete Audiological Services • Hearing Aid Dispensing & Service
Assistive Listening Devices • Electronystagmography • ABR

ST. FRANCIS MEDICAL PLAZA • 331 LAIDLEY STREET, SUITE 602 • CHARLESTON, WV 25301

President's Page

Robert P. Pulliam MD.

WORDS

TRUST – Reliance on the character, ability, strength, or truth of someone or something implying dependence on something future.

Following Senate Bill 576 passage in 1989, trust between physicians and government reached an all-time low. In the interim between that debacle and now, a slow but steady building of a trust relationship occurred primarily because Senator Joe Martin and Delegate Tom Susman worked closely with physicians in crafting the Medicaid Enhancement Tax Program. This program initially worked very well with only minor glitches as the committees, composed of consumers and providers designated by the bill, joined together to improve access for enrollees and payments to providers.

At a meeting in September, Medicaid officials presented a plan to offer voluntary tax withholding capabilities to providers in order to increase cash flow to the department, thus facilitating a draw down of federal matching dollars. During this meeting, oral assurances regarding non-discrimination in payments to providers based on participation status were extended. In fact, these statements were clearly printed on the initial mail-outs to physicians requesting voluntary tax withholding.

Despite these oral and written assurances, less than two months later, the Medicaid Department freely admits discrimination in payments based on preferred payments to providers who agreed to voluntary tax withholding and to other providers perceived by the department to be "Medicaid preferred."

This flagrant break in the established "trust building" between providers and government is unfortunate. Physicians are but a microcosm of the general population that views "our" government's actions with suspicion and distrust. Continued action by government of this sort will abort the "trust process" and lead again to poor cooperation between providers and government.

EXEMPT – To release or deliver from some liability or requirement to which others are subject.

Legislative process frequently writes exemptions into law. Most frequently, if not always, this is an error.

Consider the Blue Cross/Blue Shield bankruptcy in West Virginia. The Legislature specifically exempted Blue Cross/Blue Shield from payments to the State Guaranty Insurance Fund. This effectively granted Blue Cross/Blue Shield an economic advantage in the health insurance industry, and certainly prevented recovery by subscribers for losses caused by the company's failure. Why? -- special interest group pressure in the legislative process.

The H&H Music Company's legal reduction of an employee's health benefits because of AIDS is another example of legislative "exemptions." In this case, Congress wrote exemptions into the ERISA law to allow self-insured companies to act differently than individuals buying insurance policies. Castigation of H&H Music for using perfectly legal means to reduce benefits belies the culprit -- Congress, who bowed to special interest group pressure for exemptions.

The legislative process needs to understand that exemptions always create an unlevel playing field with results that are clearly unintended.

PARTICIPATION – The act of taking part.

This year's Mid-Winter Clinical Conference offers attendees the opportunity to participate in a discussion and evaluation of the WVSMA's positions regarding the Health Care Planning Commission's report. Senator Jay Rockefeller and Planning Commission Chairman George Farley will be the featured speakers for the combined Physician/Public Session on Friday, January 22 at 7 p.m., which is entitled "Patients and Their Doctors: What Does the Future Hold." It is vitally important that as many physicians as possible take part in the process to discuss health care charges.

Remember, participate or do not complain!

Robert P. Pulliam, M.D.

Peace

Peace reigns in the world. Or does it?

The world finds it difficult to appreciate the fact that it is in the midst of an increasingly dangerous and deadly religious war. Islam is stirring in the Middle East, Southern Europe and parts of the former USSR. India is wracked with religious turmoil.

There is great indecision about intervention in Yugoslavia at present. Military reasons are advanced for steering clear of involvement there -- the terrain is unfavorable, supplies difficult, guerilla warfare, etc. One reason that is much downplayed for avoiding intervention, is that presently in Yugoslavia, Islam is at war with Christianity and vice versa. To take sides is sure to enflame other smoldering conflicts with similar bases in fact. The same reason prevailed for our failure to beat up properly on Iraq when the opportunity was there.

Some dim awareness of such a religious conflict is expressed, but it is apparently not very nice to talk about it. As a matter of fact, there are religious stirrings throughout the world. What can account for this? Without doubt, there can be theological speculations on a source, but whatever the source, we have come to live in a world we must depict in more fearsome shapes, forms, and colors than the picture we viewed not too many years ago.

What a strange turn of events has taken place! Science, once feared by those with religious convictions because of its apparent direct path to making all of us fancy ourselves peers of God, seems now to have become the vehicle for a return to religious piety via the many avenues it has opened to self destruction rather than immortality.

Medicine's plight is perhaps just an offshoot of the general concern about science and immortality. Just as gold is valued because of its sparsity and relative permanence, and wealth because of the apparent security it offers, medical care is valued because of its relationship with good health, which is increasingly difficult to maintain with advancing age and perhaps, with advancing science.

"Health is golden" we often hear quoted. With some frequency, we hear victims of some disaster say, "As long as I have my health, I have everything." Good medical care and good health are like gold and other forms of wealth in that, once acquired, the need for more and more of the same is also acquired, along with the fear that what is now possessed will somehow be stolen.

The steadily increasing demand for health services and the steadily increasing share of Gross Domestic Product is proof enough of these conclusions.

Medicine finds itself in a position of total impotence in regard to its ability to satisfy the insatiable demands for its services. And well it should be, for we are in no position to offer anyone the immortality apparently desired.

The thought occurs -- Is the increasing demand for medical care and apparent immortality simply a reflection of the world's concern over deteriorating morality and the consequent deteriorating chances for something better when immortality fails and the hereafter is upon us?

Is the answer more science or more religion and morality? It seems unlikely that the manner of paying for any amount of medical care will influence the craving for more medical care.

The reign of peace in the world is rather shakey. Peace and serenity for those seeking firm security in any medical care plan will find an insecure habitat in the quaking hearts of men fearful of more than death.

–SDW

At Mid-Winter

Geriatric medicine topics for Third Session include Alzheimer's, restraint-free health care

Shirley M. Neitch, M.D., F.A.C.P., an associate professor of medicine at Marshall University, will be the guest moderator for this year's Third Scientific Session, "Current Issues in Geriatrics and Long-Term Care," at the WVSMA's Mid-Winter Clinical Conference in Charleston.

Scheduled for Saturday, January 23 at 2 p.m. at the Holiday Inn - Charleston House, this session will feature lectures concerning Alzheimer's disease, non-Alzheimer's dementias, the possibilities of restraint-free health care, and infection control in nursing homes. Panelists will include **Mark A. Newbrough, M.D.,** program coordinator for clinical services for the Geriatric Evaluation and Management Program sponsored by West Virginia University and the Charleston Area Medical Center; **Robert W. Keefover, M.D.,** an assistant professor in the Department of Behavioral Medicine and Psychiatry at WVU; **Gretchen E. Oley, M.D.,** associate professor in the Department of Medicine at Marshall University; and **Joye A. Martin, M.D.,** an associate professor in the Department of Family and Community Health at MU.

Information about Dr. Neitch and these panelists begins below and further details about the Mid-Winter Clinical Conference are available by contacting Nancie Divvens at 925-0342.

Neitch

Newbrough

Keefover

Oley

Martin

Moderator, panelists highlighted

Dr. Neitch received her medical degree from the Medical College of Virginia in 1977 and completed an internship and residency at the University of Virginia Affiliated Hospitals.

After her residency, Dr. Neitch began practicing general medicine at the National Health Service Corps Clinic in Fort Gay, W.Va., in July 1980. She left this position in June 1983 to join the faculty at the Marshall University School of Medicine as an assistant professor.

In January 1986, Dr. Neitch became the director of the Intermediate Medicine Unit at Veterans Affairs Medical Center in Huntington and also medical director of the Wayne Continuous Care Center. She currently still holds these two roles in addition to being an associate professor of medicine in the Department of Medicine at Marshall University, as well as the director of the Hanshaw Geriatric Center.

A very active member of the Marshall faculty, Dr. Neitch is chief of the Section of Geriatrics and serves as director of the Transitional Residency Program. She was named Clinical Faculty Member of the Year by the Marshall University School of Medicine Class of 1992.

A fellow of the American College of Physicians and a founding fellow of the Southern Society for Geriatric Medicine, Dr. Neitch is also a member of the American Geriatrics Society, the American Medical Director's Association, the WVSMA, the Cabell County Medical Society and the Christian Medical and Dental Society. She is a member of the Steering Committee of the West Virginia Association of Hospital Ethics Committee, the Education Committee of the Pennsylvania - West Virginia Chapter of the American Geriatrics Association, and also serves as an editorial board member for *Senior Patient.*

Dr. Newbrough received his medical degree from West Virginia University in 1985, and then completed an internship in general surgery and a three-year residency through WVU at the Charleston Area Medical Center.

From 1989-90, Dr. Newbrough did a fellowship in geriatrics at the WVU Health Sciences Center in Morgantown, and then he joined the WVU School of Medicine faculty as a clinical assistant professor of medicine at the Charleston Division. A year later, he was promoted to his current role as an assistant professor of medicine and was appointed to the hospital staff at CAMC.

In addition to his teaching position, Dr. Newbrough serves as program coordinator for clinical services for the Geriatric Evaluation and Management Program, which is jointly sponsored by WVU and CAMC. He also is a practicing physician at the Arthur B. Hodges Center and practices on a part-time basis at Cabin Creek Health Center.

A diplomate of the National Board of Medical Examiners and the American Board of Internal Medicine, Dr. Newbrough is a member of the American College of Physicians and the American Geriatrics Society.

Dr. Keefover is a native of Fairmont who received his medical degree from Marshall University in 1982. He then relocated to Rochester, N.Y., where he served as an instructor at the University of Rochester School of Medicine and Dentistry from 1982-85, and completed his medical internship and residency in psychiatry.

Following his residency, Dr. Keefover did additional postgraduate studies in neurology at WVU in Morgantown before assuming his current post as an assistant professor in the Departments of Behavioral Medicine and Psychiatry, and Neurology. Dr. Keefover is also presently serving as director of the Neuropsychiatry Program at WVU and has seven research projects underway.

Dr. Keefover has privileges at Ruby Memorial Hospital, Fairmont General Hospital, Mountainview Regional Rehabilitation Hospital, Louis B. Johnson Veterans Administration Medical Center, and Chestnut Ridge Hospital, where he is president of the medical staff. In 1989, Dr. Keefover completed the Stanford University course in Sleep Disorders Medicine at Stanford University in Palo Alto, Calif., and he is responsible for establishing the EEG/Sleep Laboratory at Chestnut Ridge Hospital.

Actively involved with the American Board of Psychiatry and Neurology, Dr. Keefover is also a member of the American Academy of Neurology, the AMA, American Neuropsychiatric Association, the American Psychiatric Association, the American Sleep Disorders Association, the Gerontological Society of America, the national and state chapters of the Tourette's Syndrome Association, the WVSMA, and the Monongalia County Medical Society. A popular speaker, Dr. Keefover has made nearly 50 lectures and presentations at national and state conferences and medical meetings during the past four years.

Dr. Oley received an M.A. degree in political science with an emphasis on public administration from Marshall University in 1979, where she also obtained her medical degree in 1982. She completed an internship and a residency in internal medicine at Marshall University Affiliated Hospitals and then joined the school's faculty in 1985 as an assistant professor in the Department of Medicine.

In 1990, Dr. Oley was promoted to her current post as an associate professor in the Department of Medicine, where she has also been section chief of general medicine since 1985. In addition to her academic appointments, Dr. Oley is medical director of St. Mary's Ambulatory Care Clinics and is an active staff member at Cabell Huntington Hospital.

Involved with many Marshall activities, Dr. Oley is currently chair of the school's Resident Search Committee, and a member of the Scholarship Committee, Curriculum Committee, Alumni Association Steering Committee, and the University Physicians Practice Plan and Management Committee. In addition, she is secretary/treasurer of the Beta Chapter of Alpha Omega Alpha at Marshall, and is also secretary/treasurer of the Junior Cabell County Medical Society.

A diplomate of the American Board of Medical Examiners and the American Board of Internal Medicine, Dr. Oley is presently co-investigator for a research project for Abbott Laboratories entitled "Abbott-56268 and Erythromycin in the Treatment of Community-Acquired Pneumonia."

Dr. Martin is a 1977 graduate of the Medical College of Pennsylvania in Philadelphia who completed a three-year residency at Temple University Hospital. Following her residency, Dr. Martin joined the National Health Service Corp. in July 1980, and during her three years of service attained the rank of senior assistant surgeon.

After her military service, Dr. Martin went into private practice in Barboursville and joined the clinical faculty in the Department of Internal Medicine at the Marshall University School of Medicine. In 1982, she was promoted to assistant professor in the Department of Family and Community Health, and then was elevated to her current post as an associate professor in 1986. In addition, last year Dr. Martin was appointed as a special assistant to the dean of the Marshall University School of Medicine.

Involved with the medical care at several nursing care facilities during her career, Dr. Martin is the quality care medical director for Pinnacle Care Center, and the medical director for both the Skilled Nursing Unit at St. Mary's Hospital and Outreach Services for Cabell Huntington Hospital. In addition, she is chairman of the West Virginia Nursing Home Administrators Licensing Board, and three of the current five research projects which she is conducting concern aspects of nursing home care.

The recipient of Marshall's Outstanding Professor Award in 1984, Dr. Martin was chairman of the Admissions Committee in 1992 and is presently serving as a research professor for the "Alzheimer's Disease Screening Project" in the Department of Family and Community Health.

Guest Speaker

Nancy Adams, executive director of the Stark County Medical Society in Canton, Ohio, recently addressed members of the Kanawha County Medical Society about the Mini-Internship Program which they will be conducting beginning January 31.

Tobacco Control Coalition plans Huntington workshop

The West Virginia Tobacco Control Coalition, in conjunction with Mary Babb Randolph Cancer Center, will sponsor a tobacco control conference at the Gateway Holiday Inn in Barboursville in March.

The conference will be geared toward individuals and organizations interested in forming local coalitions to develop community smoking intervention programs. Topics include an overview of tobacco control programs in West Virginia, media advocacy plans, policy and ordinance development, nicotine reduction programs and several roundtable discussions on tobacco-free initiatives for target groups. Details will also be given on grant monies available through the ASSIST project to organize community programs.

For more details about the conference or tobacco control programs in West Virginia, call Joyce Edwards at 558-0644.

Charleston House site for WVSMA Legislative Briefing, Reception

This year, the West Virginia State Medical Association's Legislative Briefing and Legislative Reception will both take place at the Holiday Inn - Charleston House on Thursday, February 18.

The briefing will begin at 3:30 p.m. and will conclude shortly before the Legislative Reception starts at 6 p.m. Reservations must be made by February 8 by phoning Winnie Martin at 925-0342.

WVU conference on family violence set for February 26-27

The WVU School of Medicine's Office of Continuing Medical Education will sponsor a conference entitled "Child, Spouse, and Elder Abuse: Breaking the Cycle of Family Violence," February 26-27, at the WVU Health Sciences Center.

This conference will define the problem of family violence in West Virginia and the nation, and identify successful methods for intervention, treatment, and prevention. The conference supports the American Medical Association's National Coalition of Physicians Against Family Violence.

For more seminar information, call the Office of CME at 293-3937 or 1-800-WVA-MARS from 8 a.m. - 5 p.m., Monday through Friday.

WVU Ophthalmology Alumni Weekend set

The 4th Annual Ophthalmology Alumni Weekend of the West Virginia University Department of Ophthalmology is set for March 5-6 in Morgantown.

The Susruta lecturer will be Ronald S. Fishman, M.D., and this year's Pangilinan lecturer is Marilyn T. Miller, M.D.

For more details, please contact the WVU Department of Ophthalmology at 293-3757.

Postgraduate course in head and neck anatomy offered

A four-day course entitled "The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy" will be held at the Medical College of Virginia, Department of Anatomy, March 1-4.

Lectures and demonstrations will augment the laboratory work. The course is approved for 40 elective hours by the American Academy of General Practice and Academy of General Dentistry.

Further information may be obtained from Dr. Hugo R. Seibel, Department of Anatomy, Box 709, Medical College of Virginia, Richmond, Va. 23298.

Children's Defense Fund schedules annual conference

The Children's Defense Fund's Annual National Conference, "Leave No Child Behind: Mobilizing Families and Communities for America's Children," will be conducted March 11-13 in Washington, D.C.

This CDF conference will offer 45 workshops and special preconference sessions on March 10 that include an advocacy training seminar and an opportunity to meet and talk with new members of the 103rd Congress.

For more details, contact the CDF Conference Hotline at (202) 662-3684, or Ann Delory at (202) 628-8787.

WVU, MU residents win honors in third trauma competition

Two WVU residents and two residents from Marshall University received awards at the Third Annual Resident's Trauma Research Competition, which was held recently in Morgantown during the West Virginia Chapter of the American College of Surgeons annual fall meeting.

The three winning papers were "Anatomical Correlation of Posterior Lateral Mass Plating/Screw Fixation With Anatomical Structures" by Kent Sauter, M.D., chief neurosurgery resident at WVU; "Blunt Thoracic Aortic Rupture at a Level II Trauma Area" by R. Scott Haupt, M.D., a surgery resident at Marshall University; and "Retrieval of an Aspirated Bullet Fragment by Flexible Bronchoscopy in a Mechanically-Ventilated Patient" by John Fulginiti, M.D., a surgery resident at WVU. In addition, Dr. Kenneth Lipshy, a surgery resident at Marshall University, received honorable mention for his paper "An Institutional Review of Splenic Trauma and Its Management."

The competition was sponsored by the West Virginia Committee on Trauma. Presentations were judged by James W. Kessel, M.D.; Thomas H. Chang, M.D.; David A. Kappell, M.D.; David A. Denning, M.D., and Howard Champion, M.D., professor of surgery and chief of the Division of Surgery for Trauma at Washington Hospital Center in Washington, D.C.

The winning papers were presented in competition at the regional Committee on Trauma meeting on December 9 in Pittsburgh.

State urologists to meet March 26-28 in Huntingtom

The West Virginia Urological Society's annual meeting, "Laparoscopy in Urology and Update on Radiation Therapy," will take place in Huntington, March 26-28.

For further information, contact Douglas E. McKinney, M.D., 11 Chenoweth Drive, Bridgeport, WV 26330 or phone 623-1001.

Book Review

Perspectives in Medical Management '92 is a publication of The American College of Physician Executives, an organization of over 6,500 physicians involved in medical management. This book is a compilation of over 75 summaries of issues facing physicians in the field of medical management, and it covers subjects such as medical informatics, health care quality, innovations in health care, and managerial effectiveness.

Timely and pertinent topics featured in the book include shaping the thinking of the medical staff from traditional quality assurance to quality improvement awareness, preparing for a successful Joint Commission survey, and quality issues involved with medical staff credentialing.

This compendium of short articles provides an excellent summary of the pertinent issues facing medical managers in today's health care environment, as well as providing insight as to how fellow physician managers are dealing with these issues in their respective institutions.

Donald H. Hofreuter, M.D., F.A.C.P.E.

Myers family subject of new book

"The House of Myers," a book written by Avanelle W. Myers, is the story of Dr. J. W. Myers, a West Virginia physician, and his five children who were all physicians.

Dr. Myers received his M.D. degree in 1895 from the Physio-Medical College of Indiana. He practiced in Barbour County from 1895 until his death in 1934. His five children were Karl J. Myers, M.D. (1899-1976)) a radiologist; Hu C. Myers, M.D. (1902-1987), a surgeon; Elmer E. Myers, M.D. (1907-1962), a clinical pathologist; Edna Myers Jeffreys Justice, M.D. (1907-1975), an obstetrician-gynecologist; and Junior W. Myers, M.D. (1913-1966), an ophthalmologist.

Dr. Myers and his sons Karl and Hu established the Myers Clinic in Philippi, where they and Dr. Elmer spent their entire professional lives. Dr. Edna practiced in Washington, D.C., and Dr. Junior in Glen Dale.

Avanelle W. Myers, the widow of Dr. Hu C. Myers, served as president of the West Virginia State Medical Association's Auxiliary from 1966-67. She had almost completed the book when she died suddenly on March 3, 1992. Her niece, Evangeline Myers Poling, M.D., and her husband, Glenn B. Poling, D.D.S., edited the book and wrote a short genealogy.

Copies of the book may be purchased from the Philippi Public Library or the Barbour County Historical Museum, both in Philippi, for $6 plus $1.50 for mailing costs.

Liability Issues

Dr. Richard Capito was one of the featured speakers at "Current Liability Issues Impacting West Virginia Emergency Departments," a seminar in Charleston which was sponsored by the West Virginia Hospital Research & Education Foundation and the West Virginia Hospital Insurance Company.

Revenue Optimization

What is Revenue Optimization?
Revenue Optimization addresses the fundamentals which govern your gross revenue and, therefore, your net income.

FEE ANALYSIS
- Your fees are converted to a relative value basis using the Systemetrics-McGraw/Hill relative value system.

CODING/REIMBURSEMENT ANALYSIS
- We analyze and evaluate your procedure code usage (and non-usage), including levels of service for the office, hospital, consultation and ER/Outpatient service as well as your use of modifiers.
- We review your insurance claim forms and your EOBs to find ways to maximize your reimbursements, minimize reductions and denials, and minimize the chance of audit.

MEDICARE/RBRVS
- The primary function is to protect your revenue under both par and non-par status, enabling you to make a rational and objective decision about your participation status with Medicare.
- In the process, we calculate your Medicare allowed amount and the co-payment amount for every procedure under both par and non-par status. RBRVS Analysis is included, showing you the effect of RBRVS on each code you use and on all codes collectively.

ON-SITE CODING/ REIMBURSEMENT
- If your personnel needs hands-on help, we come to you. We "audit" your complete reimbursement system including: procedure coding, diagnosis coding, charges, claims filing, reimbursements, and chart documentation. If needed, we will provide classroom and hands-on training for individuals or your entire staff.

YOUR SATISFACTION IS GUARANTEED
- If we do not help or if you are not satisfied with the results of your analysis — your money will be refunded!

America's Premier Consulting Firm Advising Physicians Throughout Our Nation Since 1956

RCFA Physician Managers Inc.

9724 Kingston Pike, Suite 1200
P.O. Box 23590
Knoxville, TN 37933-1590

Professional Practice Planners

332 Fifth Avenue • Suite 213
McKeesport, Pennsylvania 15132

Call Stan Pollock,
DMD, CFP, PHD, CPBC, CBA

(412) 673-3144 • 1-800-635-4040

American Medical Association

Physicians dedicated to the health of America

For Your Benefit

AMA advocates unity in health system reform

In his keynote address at the American Medical Association's Interim Meeting, AMA President John Lee Clowe, MD noted that elements of the AMA's Health Access America plan appeared in platforms of both political parties during the November election. These elements are expected to be incorporated into most of the legislation likely to come before the 103rd Congress. The AMA wants to enhance physician involvement in public and private regulation of medical care, encourage implementation of market-oriented reforms, and prevent adverse patient care that would result from price controls or stringent global budgets.

Most of the major players in the health system reform debate "realize that they can't achieve reform without the participation of the medical profession. Medicine must speak with one voice in the health system reform debate. Most look to the AMA as the voice of organized medicine in this process of change," he said.

AMA urges safeguards for patients' computer records

AMA testimony before the federal Task Force on Privacy of Private Sector Health Records pressed for more complex security for computerized patient records to protect privacy and to avoid legal problems. The AMA emphasized that patient records must remain confidential, accurate, comprehensible, and free from unauthorized access. The AMA recommends that physicians and other health care providers be expected to use reasonable safeguards, since there is no fail-safe protection.

New AMA guidelines focus on elder abuse

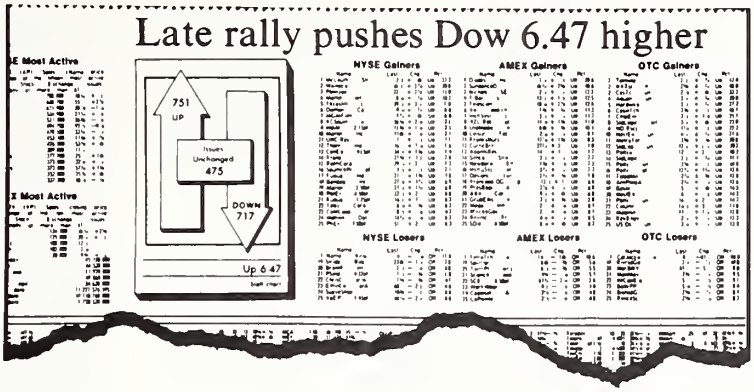
The AMA has issued its first guidelines on elder abuse, urging physicians and other health care professionals to be more alert to signs of neglect or mistreatment of older patients by families or other care givers. An estimated two million U.S. elderly are mistreated each year. "A physician may be the only person outside the family who sees the older adult regularly," said AMA Board of Trustee, Palma E. Formica, MD.

The AMA guidelines recommend physicians incorporate standard questions to screen for mistreatment into routine care.

- Be aware that abuse may be physical, psychological, financial or material, or any combination of these.
- Be aware that in institutions, elder abuse may be perpetrated by a staff member, another patient, an intruder or a visitor.
- Many states require physicians to report suspected elder abuse to designated state agency.
- Your duty to report suspected abuse supersedes doctor- patient confidentiality issues, most experts say.

Materials included are excerpted from *Member Matters*, a monthly publication sent to all members of the American Medical Association.

Avoid capital gains tax. Support the American Heart Association.



By supporting the American Heart Association you may:

- avoid capital gains tax on appreciated securities or other property
- reduce current and future income taxes
- provide a lifetime income for yourself or beneficiaries
- avoid probate and publicity
- maximize estate tax savings

It may pay you to inquire about the American Heart Association's Planned Giving Program.

Sometimes, it can be better to give than to receive.

American Heart Association

This space provided as a public service.

Wonderful WEST VIRGINIA

If there's one magazine that should be in YOUR waiting room, it's definitely **Wonderful WEST VIRGINIA**

Wonderful WEST VIRGINIA will entertain your patients with articles on historic places, state parks and forests, recreational opportunities and our beautiful flora and fauna. In addition, the magazine will continue to feature West Virginia's scenic beauty in stunning color photographs.

For a special low price of $10.00 a year -- *60% off the newsstand price*-- you can have your waiting room filled with West Virginia pride!

Just call our office at 558-9152 to start your subscription today!

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

The programs this month were compiled by: Nancie Divvens, executive assistant for the West Virginia State Medical Association; Robin Rector, coordinator for CME for Charleston Area Medical Center; Kari Long, program director of CME and rural services for WVU; and Thelma Wilson, education coordinator for Raleigh County Medical Society.

More details about these CME activities may be obtained by calling Divvens at 925-0342; Rector at 348-9580; Long at 293-3937; and Wilson at 255-6341.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

Jan. 21-24 - 1993 Mid-Winter Seminars and WVSMA/WVACP Scientific Conferences, Charleston

CAMC/WVU Health Sciences Center - Charleston

Jan. 21 - "New Emergency Drugs - Pharmacy Review," (teleconference), 12:30 p.m. - 1:30 p.m., WVU Health Sciences Center, Room 2014AB

Feb. 2-3 - "Cardiovascular Conference at Snowshoe," (Co-sponsored by the American College of Cardiology), Snowshoe Mountain Resort, Snowshoe

Feb. 4 - "Continuum of Care for Stroke Patients," (teleconference), noon, WVU Health Sciences Center

Feb. 4-6 - "Diabetes: Risk, Recognition and Intervention," Snowshoe Mountain Resort, Snowshoe

Feb. 6-7 - "Advanced Trauma Life Support (ATLS)," CAMC Training Center

Feb. 18 - "Weaning the Vent Patient," (teleconference), noon, WVU Health Sciences Center

WVU Health Sciences Center - Morgantown

Feb. 26-27 - "Child, Spouse and Elder Abuse: Breaking the Cycle of Family Violence," WVU Health Sciences Center

Raleigh County Medical Society - Beckley

Jan. 21 - "The Nuts and Bolts of QA/UR," Lee Pratt, M.D., 6:30 p.m., Black Knight Country Club

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Fairmont ★ Fairmont General Hospital, Feb. 2, 7:30 p.m., "Pediatric Orthopedic Problems," Eric James, M.D.

★ Fairmont Clinic, Feb. 17, 1 p.m., "Depression," P. Van Nickell, M.D.

Gassaway ☐ Braxton County Memorial Hospital, Feb. 10, 7 p.m., "Head Trauma," John Schmidt, M.D.

Madison ☐ Boone Memorial Hospital, Feb. 9, 6:30 p.m., "Geriatric Psychiatry," James Griffith, M.D.

Man ☐ Man Appalachian Regional Hospital, Feb. 16, 7 p.m., "Breast Cancer," Roberto Kusminsky, M.D.

Montgomery ★ Montgomery General Hospital, Feb. 3, 12:15 p.m., "Multi-drug Resistance in Cancer Treatment," Arvind Kamthan, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Feb. 3, 7 a.m., "Seizures in Children," John Bodensteiner, M.D.

★ Camden-Clark Memorial Hospital, Feb. 24, 7 a.m., "Hepatitis From A through E," John Thomas, Ph.D.

Philippi ★ Broaddus Hospital, Feb. 11, 7 p.m., TBA

Point Pleasant ☐ Pleasant Valley Hospital, Jan. 28, TBA

☐ Pleasant Valley Hospital, Feb. 25, noon, "Multi-drug Resistance in Cancer Treatment," Arvind Kamthan, M.D.

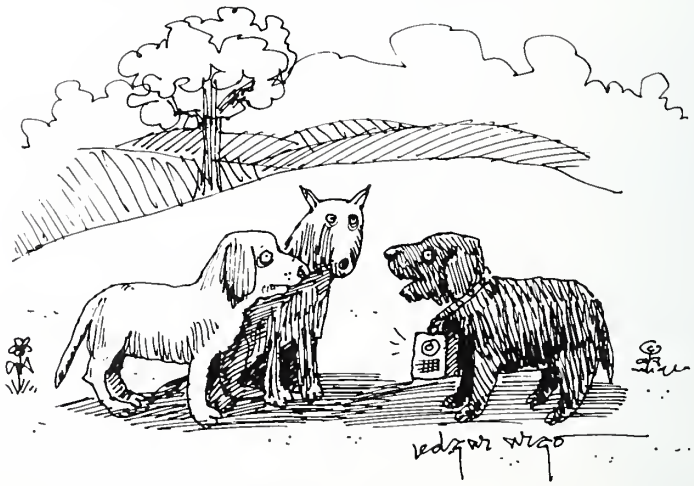
Ripley ☐ Jackson General Hospital, Feb. 12, 12:15 p.m., "Estrogen Replacement Therapy," Paul Fulcher, M.D.

Spencer ☐ Roane General Hospital, Feb. 19, 12:30 p.m., "Clinical Health Psychology," Paul Blanton, Ph.D.

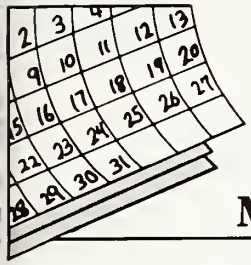
White Sulphur Springs ★ Greenbrier Clinic, Jan. 25, 4 p.m., "Evaluation of Abdominal Aortic Aneurysms," Kenneth Granke, M.D.

★ Greenbrier Clinic, Feb. 22, 4 p.m., "New Concepts in the Management of BPH," Stanley Kandzari, M.D.

Williamson ☐ Williamson Appalachian Regional Hospital, Feb. 25, 5:30 p.m., "Health Promotion and Disease in the Elderly," Mark Newbrough, M.D.



"I HAVE TO GO... I'M BEING BEEPED."



Medical Meetings

January

21-24—1993 Mid-Winter Seminars and WVSMA/WVACP Scientific Conferences, Charleston
29-30—Transfusion Medicine: Update 1993, American Association of Blood Banks (sponsor), Atlanta
31-Feb. 3—American Hospital Association, Washington, D.C.

February

1-3—Cardiovascular Conference at Snowshoe, American College of Cardiology, CAMC and WVU (sponsors), Snowshoe, W.Va.
3-4—Blood Bankers Taking Action: AABB Legislative Advocacy Workshop, American Association of Blood Banks (sponsor), Washington, D.C.
4-7—American Society for Adolescent Psychiatry, San Diego
7-11—Southeastern Surgical Congress, Tarpon Springs, Fla.
12-14—American Academy of Pain Medicine, San Diego
12-15—American Association for Geriatric Psychiatry, New Orleans
15-18—1st International Congress on Medical-Legal Aspects of Work Injuries, Kenes-Gil Travel (sponsor), Jerusalem, Israel
18-23—American Academy of Orthopedic Surgeons, San Francisco
20—Obsessive/Compulsive Disorders, Ohio State University (sponsor), Columbus
25-26—11th Annual International Symposium on Man and His Environment in Health and Disease, American Environmental Health Foundation, Inc. (sponsor), Dallas
26-March 3—California Medical Association's 122nd Annual Session and Western Scientific Assembly, Anaheim, Calif.

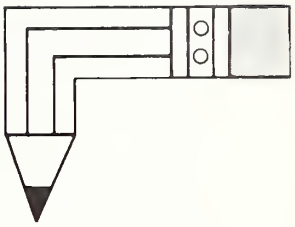
March

1-4—Alton D. Brashear Postgraduate Course in Head and Neck Anatomy, Medical College of Virginia (sponsor), Richmond
5-6—36th Annual Ophthalmology Symposium: Ophthalmic Plastic Surgery for the 1990s, Ohio State University (sponsor), Columbus
5-6—4th Annual Ophthalmology Alumni Weekend, WVU Dept. of Ophthalmology (sponsor), Morgantown
13—Depression: Medical Perspectives on Diagnosis and Management, Ohio State University (sponsor), Dublin, Ohio
21-26—Cardiovascular Disease-The High-Risk Patient: An Interspecialty Approach, Ohio State University (sponsor), Snowmass-Aspen, Colo.

For More Information . . .

Contact the Journal at (304) 925-0342 for additional information about most of the above meetings.

Poetry Corner



On My Retirement

Many have asked me why I'm retiring
When I'm only fifty-nine,
Especially since the income is good
And my health is still just fine.

In '65 when I started practice
Patient volume was rather slow,
I didn't make much money back then
'Cause my fees were also low.

One nurse and one receptionist
Assisted and obeyed me,
And patients seemed so grateful then
Most of them even paid me.

But gradually conditions changed
And the patient volume grew,
The income and fees increased a lot
And many things were new.

As the practice and the staff enlarged
It tested my endurance,
'Cause I wasn't dealing with patients now
I was dealing with their insurance.

It seemed the proper thing to do
To play ball with Medicare,
And sign up with every HMO
To insure my market share.

I joined some plans reluctantly
Their rules put me ill at ease,
But they were good at seducing me
With the promise of higher fees.

With the rising costs and easier access
I had trouble comprehending,
How all these health plans were, indeed,
Controlling health care spending.

My staff of two had grown to twelve
Overhead was out of sight,
It took a lot of expertise
To fill those forms out right.

The time I spent with CME
Was very much outweighed,
By learning the procedure codes
To make sure I got paid.

Insurance claims got so complex
The tale is sad to tell,
We bought a new computer
To relieve our personnel.

The software package was up to date
So the salesman guaranteed,
But a second dealer made it clear
An update was what we need.

I practiced defensive medicine
Afraid to try something new,
Though the treatment seemed appropriate
The patient, of course, might sue.

The government has done its "darndest"
To control this medical mess,
They gave us in addition to Medicare
OSHA, CLIA and R.B.R.V.S.

Administration is a full-time job
And by now I'm just exhausted,
I used to manage employees well
But by now I think I've lost it.

I mentioned to my wife one night
As I lay in bed beside her,
I'm not called doctor anymore
I'm called "health care provider."

It's still a joy to treat a patient
Cure their rash, their pain, their itch,
But with all these rules and regulations
It's time to let someone else get rich.

Harold L. Saferstein, M.D.

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Second dose MMR available for state's 6th graders

The Bureau of Public Health, in conjunction with the state Department of Education, is offering a voluntary second dose of the Measles/Mumps/Rubella (MMR) vaccine to West Virginia's sixth graders. This second dose is offered for preventive measures at the recommendation of the Advisory Committee on Immunization Practices and the American Academy of Pediatrics.

Over 13,000 doses of MMR will initially be distributed to the county health departments in preparation for the campaign. This number is equivalent to the amount administered to state sixth graders during the 1992 campaign. More vaccine will be made available by the Bureau's Immunization Program should there be a greater demand than expected.

Immunization clinics will be conducted statewide during January, February and March, and clinic schedules will vary from county to county.

For more details about the project, contact Derald Rollyson of the Immunization Program at 1-800-642-3634 or 558-2188.

Bureau increasing emphasis on nutrition

The Bureau of Public Health is implementing several new nutrition-related projects in an effort to increase the health of West Virginians through better eating habits.

Bureau staff members have been instrumental in the organization of the statewide West Virginia Coalition on Foods and Nutrition (WVCFN). The new executive director of the coalition is Margaret Williams of the Eastern West Virginia Community Action Agency in Moorefield. Williams will be traveling throughout the state in the next few months to study issues concerning food, nutrition and hunger in West Virginia, and she will be actively engaged in advocacy during the upcoming legislative session.

Gloria Wagner has joined the Bureau's Division of Health Promotion as a nutrition specialist. She will be working closely with the WVCFN, as well as with the state Women, Infants and Children (WIC) supplemental food program. Wagner will also be involved in nutrition program planning in conjunction with the Bureau's cardiovascular disease program and the public employee worksite wellness program, WV HealthStyles.

New OCRH staff to encourage more provider partnerships

The Office of Community and Rural Health (OCRH) has several new staff members who will be working to encourage more links between private and public providers in an effort to make quality health care more accessible around the state.

Christina Gordon, M.P.H., formerly of Southern West Virginia Regional Primary Care Centers, Inc., has been named assistant director for OCRH. In addition to working with the office's five divisions, Chris serves as staff to the Commissioner's Advisory Group, which was formed this summer to address issues affecting local health departments and boards of health.

Elise Jensen, M.P.H., has joined the OCRH staff as acting director of the Office of Rural Health Policy. She will be working to improve coordination and communication between individuals and organizations, including the state's three medical schools, which provide health services to residents in rural West Virginia. Jensen comes from the Office of Epidemiology and Health Promotion where she was involved in community-based health promotion efforts.

Jim Doria holds the new position of associate director for the Office of Emergency Medical Services. He has been involved in numerous research projects within the Bureau and will now be using EMS data for the research and development of injury prevention initiatives. Doria will also oversee legislative issues relating to emergency medical services, including the "Two for Life" bill.

Craig Robinson, M.P.H., has been named coordinator of the Comprehensive School Health Program within the Division of Primary Care and Recruitment. During this short-term project, he will be responsible for developing a plan to link primary care centers with schools to provide more accessible health services to school-age children. The goal of this program is to improve the health of these students and, in turn, improve their preparedness to learn and function. Robinson comes to OCRH from New River Health Association, Inc., where he served as administrator.

For more information on OCRH programs, call 558-3210.

Links found between smoking and SIDS

Women who stop smoking during pregnancy, but renew the habit after birth may still be putting their babies at risk for Sudden Infant Death Syndrome (SIDS), according to a recent study by the National Center for Health Statistics in Maryland.

The report says babies exposed to their mothers' smoke only after birth were two times more likely to die of SIDS than babies never exposed to smoke. It also indicated that babies born to a mother who smoked both during and after pregnancy were three times more likely to die of SIDS.

A Bureau of Public Health study in 1990 found that 34.6 percent of West Virginia women of the childbearing ages between 25 and 34 smoke. State Tobacco Control Program officials say these statistics make the information from this new study even more alarming. Staff members are currently working with other health organizations through the ASSIST project to develop programs that warn these women about the dangers of smoking.

West Virginia Chapter

American College of Surgeons

Annual Spring Meeting **April 29 - May 1, 1993**

The Greenbrier - White Sulphur Springs, West Virginia - 10 Hours CME

Guest Speakers:

Louis Del Guercio, M.D.
Professor and Chairman, Surgery
New York Medical College

Eddie Joe Reddick, M.D.
Nashville, Tenn.

R. Phillip Burns, M.D.
Professor and Chairman, Surgery
Chattanooga Unit-University of Tenn.

Other Statewide Speakers, Including the Annual Residents' Competition-Saturday, Tennis Tournament-Thursday, Golf Tournament-Friday.

Registration: WV Chapter American College of Surgeons
P.O. Box 1107
Morgantown, WV 26505

Rooms: (304) 536-1110

HealthCare Financial Services, Inc.

1204 Kanawha Boulevard, East
Post Office Box 3882
Charleston, West Virginia 25338

"Your Medical Collection Service"

Affiliated with Charleston Area Medical Center, Inc.

We are proud to be the largest and most sophisticated collection service in West Virginia. Our emphasis is service and client image and our services are marketed exclusively to health care providers. Please call today for a review of our services and what we can do to assist your cash flow position.

J. Bruce Dunlap
Director of Operations

Thomas Harris
Marketing Supervisor

304-345-4371

In WV 1-800-369-4371

FAX 304-345-4323

WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

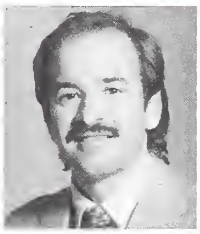
Compiled from material furnished by the West Virginia University Health Sciences Center, Communications Division, Morgantown.

Six new faculty join Charleston Division

O'Neal

Lucente

Bors


Swain

Dewitt

Gibson

James F. O'Neal, M.D., Frank C. Lucente, M.D., Kathleen P. Bors, M.D., Randall A. Swain, M.D., Michael S. Dewitt, D.O., and Leo B. Gibson Jr., D.O., have recently received appointments at WVU, Charleston Division.

Dr. O'Neal has been appointed assistant professor in the Department of Medicine. Before joining the faculty, he served his residency at CAMC, where he was chief resident from 1991-92. Dr. Lucente, who was also a resident at CAMC, has been appointed to the Department of Surgery.

The four other new faculty members, Drs. Bors, Swain, Dewitt and Gibson, are with the Department of Family Medicine. Drs. Bors and Swain are both 1987 graduates of WVU and are certified by the American Board of Family Practice. Drs. Dewitt and Gibson are 1989 graduates of the West Virginia Osteopathic School of Medicine, who both completed residencies at the Kanawha Valley Family Practice Center.

CDC grant to aid rural injury prevention, emergency care

The Centers for Disease Control has awarded a three-year, $3 million grant to the Center for Rural Emergency Medicine (CREM) at WVU to establish programs to prevent accidental injury and improve emergency care in rural West Virginia.

The grant will allow WVU to study patterns of injury in rural areas, devise strategies to reduce the incidence of injuries, and train emergency medicine providers and trauma care workers for the types of injuries they are most likely to encounter.

"We are going to coordinate our efforts with the West Virginia Office of Emergency Medical Services, the Jon Michael Moore Trauma Center, and the Office of Epidemiology to come up with prevention strategies that can save lives and avoid injuries," says Dr. John Prescott, a WVU emergency physician and director of CREM. "There are other such centers in the country, but this is the first one focused on rural injuries and training."

Jacques named chair of family medicine

Dr. C.H. Mitch Jacques has been named chair of the Department of Family Medicine, Charleston Division.

Dr. Jacques comes to WVU from Texas Tech University Health Sciences Center, where he was vice chair and residency director of the Department of Family Medicine. He has also served as associate director of residency education at Williamsport Medical Center and assistant professor and coordinator of research at Penn State University.

Dr. Jacques received his doctorate in chemical engineering from North Carolina State University in 1973 and his medical degree from Michigan State University in 1981. He is certified by the American Board of Family Practice and is a member of the National Committee on Research of the American Academy of Family Physicians.

CAS names Hedge chair-elect of council

George A. Hedge, Ph.D., associate dean for research and graduate studies, was recently named chair-elect of the Council of Academic Societies (CAS), an organization of some 90 academic and professional groups of medical school faculty.

Hedge

The CAS represents 70,000 faculty members at the 126 medical schools in the United States. It is one of the three councils of the Association of American Medical Colleges (AAMC). The other councils represent medical school deans and teaching hospitals.

Dr. Hedge, a physiologist, has been with the WVU faculty since 1977.

Residency program receives recognition

The American Board of Psychiatry and Neurology and the American Board of Internal Medicine have recognized the combined medicine and psychiatry residency program, which was developed at WVU in 1978.

This residency program is now listed in the Directory of Graduate Medical Education Programs. Two practicing West Virginia physicians, Dr. Samuel Guy, of Parkersburg, and Dr. Morgan Lyons, of Morgantown, were the first residents accepted into WVU's program in 1978. Since then, 15 physicians have received dual certification.

Where quality is affordable . . .

Participating Dealer For AMERINET, SUNHEALTH, and VHA ACCESS

BEAUTIFUL OFFICE SUITES in easy to visualize arrangements featuring styles in TRADITIONAL, CONTEMPORARY, PERIOD and more. Enjoy the beauty of CHERRY, OAK, MAHOGANY and WALNUT. You'll find them all on our showroom floors.

CUSTOM OFFICE FURNITURE, INC.

1260 GREENBRIER ST. CHARLESTON, WV 25311

INTERIOR DESIGN SERVICE
SPACE PLANNING

PHONE 343-0103 or 1-800-734-2045
WV CONTRACTOR NO. WV008652

25TH ANNIVERSARY
Eye & Ear CLINIC OF CHARLESTON INC.
The Laser Surgery Center
1967-1992

- **35-bed JCAHO Accredited Hospital**
- **Ambulatory Care/ Same Day Surgery**

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH
EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD

Specializing in
Head and Neck Cancer Surgery
Cosmetic Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

Biomedical Ph.D. program receives accreditation

The North Central Association of Colleges and Schools has approved Marshall University's doctoral program in biomedical sciences, enabling the university to award its first Ph.D. degrees.

According to Marshall University President J. Wade Gilley, North Central immediately revised Marshall's accreditation statement after the approval to include the doctoral program. "The biomedical sciences graduate program unquestionably is one of Marshall's centers of excellence," Gilley said. "In actuality, our faculty have provided all of the teaching and directed the students' research from the beginning. Our graduates are attaining distinction in their fields, and there is no better endorsement of a program's strength."

School of Medicine Dean Charles H. McKown Jr., M.D., said the change benefits not just Marshall, but the region as well.

"This is a bold, bold step for Marshall and a reflection of the evolution of the university," Dr. McKown said. "Over the last 15 years, we have expanded our reputation as a regionally renowned liberal arts school with a special interest in training educators to include strong programs in health, business and science as well. This further reinforces Marshall and Huntington as a regional biomedical and health center. This decision is also a phenomenal tribute to our faculty members who teach both the medical students and graduate students. It recognizes their ability, the success of their scientific inquiry, and the strength of the program they have taught from its inception," he added.

The North Central evaluation team that performed the site visit praised the cooperative working relationships among faculty members, the aggressive efforts to obtain grant funding, and the high-quality computer resources available.

"...[T]here is a spirit of cooperativity and interaction among the faculty that really makes this an interdisciplinary program," the team's report says. "Frequently, grants are written across interdisciplinary lines and people told engaging stories of how their research activities have changed given what they have found their colleagues doing."

In addition, the report stated that besides having the necessary academic background to successfully provide the program, "The faculty ... are serving as excellent role models, both personally and as researchers, for the students they train and come in contact with on a daily basis."

The report further commented that granting stand-alone status will also trigger changes in the curriculum, make Marshall more competitive for grants, and set the stage for more collaborative research projects between the basic medical sciences faculty and members of the natural sciences, math and psychology faculties.

MU developing wellness program for PEIA participants

The Public Employees Insurance Agency (PEIA) has awarded MU a $125,000 grant to implement a pilot program designed to promote wellness among PEIA-insured participants.

The project is a cooperative effort between Marshall's Sports Science and Wellness Institute and regional hospitals to promote a healthier populace by encouraging participants to take preventive wellness measures.

"This is another example of Marshall's role as an interactive university," MU President J. Wade Gilley said. "We look forward to a partnership with PEIA and the hospitals to help improve the health of a large segment of our population."

"Project Well/Fit" will work with PEIA participants in Cabell, Lincoln, Logan, Mason, Mingo and Wayne counties. It will focus on circulatory disorders and diabetes because of the prevalence of those problems in the region. Participating hospitals include St. Mary's, Pleasant Valley, Logan General and Williamson Memorial.

"We're very pleased to be involved in this team effort to improve preventive health care in our area," St. Mary's Executive Director/CEO J. Thomas Jones said. "By working together and pooling resources, we can maximize the benefits at the least cost to patients."

The project will include awareness education through newsletters and direct mailings, physical assessment screenings, and wellness program opportunities offered by Marshall and the participating hospitals. Those efforts will be followed with screenings to evaluate how well the program encourages healthier behavior.

Rick A. Robinson of Marshall's staff will serve as project director. "It is a perceptive move by the insurance industry, looking at health care from the other end and promoting preventive medicine as opposed to treating an illness," he said.

PEIA plans to institute several pilot wellness programs, and the most successful initiatives will be replicated throughout the state.

Speech-language pathology master's program accredited

Marshall University's master's degree program in Speech-Language Pathology has received the maximum five-year accreditation from the American Speech-Language-Hearing Association, according to Dr. Gerri Kahn, chair of the ASHA Educational Standards Board.

Kathryn H. Chezik, chair of the Communication Disorders Department, said the accreditation site committee had many positive comments about the quality of Marshall's students and faculty.

"Overall, we are very pleased," Chezik said. "I've been told that it is somewhat unusual for a program to be accredited on its first try."

EVEN WITH MS, GEORGE GANT HAS DESIGNS ON THE FUTURE

George is working his way up the corporate ladder a little differently. He's using a "scooter." Because George has multiple sclerosis, a chronic disease of the central nervous system.

A chemist, George is not content to sit back and mount up patents and industry awards. He has earned honors from almost a dozen state and local organizations for his contributions to the community.

Now, George develops quality improvement programs for his Michigan-based employer and helps to integrate other physically challenged workers into the corporate mainstream.

While his physical future is uncertain, George is unyielding in his belief that someday a cure for MS will be found. The National Multiple Sclerosis Society is bringing that day closer by funding vital research in genetics, virology and immunology. To find out more about the Society and its services, call 1-800-624-8236. Help a quarter of a million Americans with MS help themselves.

HELP US HELP OURSELVES

NATIONAL MULTIPLE SCLEROSIS SOCIETY
205 EAST 42 STREET NEW YORK N Y 10017 5706 (212) 986-3240

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

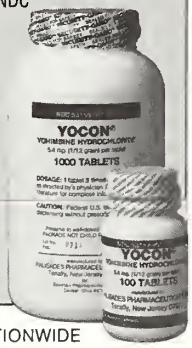
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Auxiliary News

Get involved in the 1993 Legislative Session!!

Only a few weeks remain until the Legislature goes into session. Phrases such as managed care, universal coverage, pay or play, insurance reform, and of course, the Health Care Planning Commission, have been topics of conversation at the dinner table, during auxiliary and medical society meetings, and even in the grocery store. We talk and talk and talk about these issues, but . . . the question still remains - - "What are we going to do about it?"

The answer -- get involved!

Through the WVSMAA KEY CONTACT PROGRAM, physicians and spouses can choose a legislator from their county and make a point of interacting with him or her, so when an issue arises, they can phone or talk personally with this individual about the legislation. The Key Contact Program builds strong relationships that are vital to the legislative process.

The LEGISLATIVE RECEPTION, which the WVSMA is hosting on Thursday, February 18 at 6 p.m. at the Holiday Inn - Charleston House, is another excellent way of meeting personally with senators and delegates. This event provides us with the opportunity to explain our views and let our lawmakers know how concerned we are about health care issues in West Virginia.

A third means of becoming involved in the political process is by utilizing the PHONE TREE. This tool was very effective last year when the lay midwife bill was about to pass. Comments were made by several legislators that they received numerous phone messages opposing the bill.

In addition, VISITING THE STATE CAPITOL AND ATTENDING COMMITTEE MEETINGS is also an important way to be have input into legislative matters. Not only does it allow you the chance to meet with your delegate or senator, it also enables you to see the legislators at work and make your presence known. I am pleased that the county auxiliaries closest to Charleston have agreed to attend committee meetings as much as possible so they can keep others informed.

It is every citizen's responsibility to be aware of the laws and policies that govern our state. It is also our responsibility to participate in changing or improving those laws. The WVSMA Auxiliary has done just that. Delegate Robert Kiss, on our behalf, is having legislation drafted that would require couples applying for a medical license to be provided with information and statistics relating to family violence, the signs that lead to a battering relationship, and the laws that protect the victim and prosecute the abuser. Our goal is to prevent family violence by increasing awareness of this tragic problem.

This year, more than any other, physicians and auxilians must join together -- we must become involved!

Pacita Salon
WVSMAA President

Davis & Davis Accounting Services

602 Tennessee Avenue • Charleston, WV 25302
• 304-343-4656 • 800-281-4572 • FAX 304-343-4657

Davis and Davis Accounting provides efficient electronic medical billing to help you receive faster reimbursement. We can bill insurance companies daily, weekly, monthly and/or on demand. As a result of prompt billing, the turnaround time on your reimbursement claims can be reduced by as much as 30 days.

We provide:

- filing of all primary and secondary insurance claims
- patient billing - as lump sum or budget payments
- collections - open line posting, follow up letter on late payments, problem accounts (three letters and turn over for collection)

Billing System equipped with:

- line error checking
- account aging
- cycle billing capablilities
- open line posting
- custom reports tailored to you individual practice

ASSOCIATES IN OBSTETRICS AND GYNECOLOGY

OFFERING PERSONALIZED CARE 24 HOURS A DAY 7 DAYS A WEEK
FOR OBSTETRICAL & GYNECOLOGICAL EMERGENCIES & FOR INFANT DELIVERY

OUTPATIENT & OFFICE SURGERY

9 MEMBER GROUP OF OB-GYN SPECIALISTS

CHARLES W. MERRITT, M.D.
ROBERT P. PULLIAM, M.D.
OWEN C. MEADOWS, M.D.
MICHAEL T. WEBB, M.D.
ANGEL L. ROSAS, M.D.
NANCY R. WEBB, M.D.
NORMAN W. TAYLOR, M.D.
WILLIAM A. SCARING, M.D.
NORMAN L. SIEGEL, M.D.

- CONTRACEPTIVE COUNSELING
- ARTIFICIAL INSEMINATION
- UROLOGICAL EVALUATIONS & TREATMENT
- INFERTILITY EVALUATIONS
- BREAST SCREENING

255-1541

410 CARRIAGE DR. BECKLEY

EN&T Assoc. of Charleston, Inc.

James T. Spencer, Jr., M.D.
Charles D. Crigger, M.D.
Roger P. Nichols, M.D.
F. Thomas Sporck, M.D., F.A.C.S.
Ronald L. Wilkinson, M.D., F.A.C.S.
All Physicians Board Certified

Complete Medical/Surgical Care of Ears, Nose & Throat
Including Respiratory Allergies

342-0124
Medical Office Building North, Suite 200
500 Donnally Street

WESPAC Members

The following is a list of 1993 WESPAC members. Thank you for your contributions.

Physicians

Boone
Robert B. Atkins
Ernesto T. Yutiamco

Cabell
Joye A. Martin
S. Kenneth Wolfe
Surendra Sharma
Subrat K. Lahiry
Robert J. Marshall
Craig Morgan
David M. Heffernan
*John P. Sheils
*Ralph A. Stevens II
**Jose Ricard
**Paul A. Blair

Central
Joseph B. Reed
Stephen M. Smith
*Rigoberto R. Ramirez
**Greenbrier D. Almond

Eastern Panhandle
Peter Markovic
Michael W. Strider
Edward P. Quarantillo Jr.
Daniel E. Hendricks
Ophas Vongxaiburana
Edward L. Pinney Jr.
*Edward Arnett

Fayette
Shahrooz S. Jamie

Greenbrier
Thomas F. Mann
Steven A. Issenberg
*Stephan Thilen

Hancock
Karen M. Gross
**Robert C. Solomon

Harrison
Chinmay Datta
Teodoro G. Medina
Frank C. Gyimesi
Carl W. Liebig
*Louis F. Ortenzio Jr.
*Douglas McKinney
*Thomas Chang
*Catalino B. Mendoza Jr.
*Mehmet V. Kalaycioglu
**John J. Crossen
**James L. Bryant

Kanawha
Richard A. Lewis
Horatio A. Spector
William H. Carter
William G. Sale III
Jimmie L. Mangus
Tony C. Majestro
Samuel A. Strickland
Richard H. Sibley
Stephen K. Milroy
Herbert A. Tipler
Ned T. Shanmugham
Chung W. Kim
Isidro P. Uy
Mohammed M. Boustany
Nathan A. Vaughn
*James W. Kessel
*Michael O. Fidler
*Terry R. Perrine
*Carolyn Perrine
*Martin Wershba
*Donald E. Farmer
*L. Blair Thrush Jr.
*Thomas R. Douglass
*Gina R. Busch
*Edmundo E. Figueroa
*Cecilio V. Delgra
**William A. Deardorff
**William L. Harris
**Chandra M. Kumar
**Prasadarao B. Mukkamala
**Ronny H. Go
**Hans Lee
**Samuel R. Davis

Logan
*Harry D. Fortner

Marion
John A. Rizzo
Sitha R. Katragadda
Eusebio G. Cadogan
**Harry G. Kennedy
**Mani Khatib-Shahidi

Marshall
*Kenneth Allen

Mason
Benjamin J. Sol
*John A. Wade Jr.

McDowell
*Muthusami Kuppusami

Monongalia
Robert M. D'Alessandri
Vadrevu K. Raju
Indira Majumder
Roger A. Abrahams
James Shelley
*Roger E. King
*Richard Kerr
*Donald Lamm
*Wade B. Stoughton
*Stephen L. Sebert
*Stephen R. Powell
*Gregory Timberlake

Ohio
Donald H. Hofreuter
Martin D. Reiter
Charles H. Staab III
Regina M. Barberia
Charles V. Porter
Richard F. Terry Sr.
Carl J. Kite
Frederick J. Payne
Carlos A. Vasquez
Ellen L. Kitts
Vincente P. Almario Jr.
Gregory S. Merrick
*Dennis R. Niess
**David A. Bowman
**James Comerci

Parkersburg Academy
Michael A. Santer Jr.
Richard E. Johns
E. Samuel Guy
N.N. Reddy

Potomac Valley
Carl A. Liebig

Raleigh
John M. Daniel
Charles R. Daniel
Sung W. Chang
Prospero B. Gogo
Husam M. Nazer
Cecil C. Graham
*Anne D. Hooper
*Donald L. Rasmussen
**Norman W. Taylor
**William A. Scaring
**Nancy Webb
**Michael T. Webb
**Robert P. Pulliam
**Charles W. Merritt
**Owen C. Meadows Jr.
**Iligino F. Salon
**Norman L. Siegel
**Angel L. Rosas-Acededo

Tug Valley
Diane E. Shafer
Tarum M. Dharia

Tygarts Valley
Stanley S. Masilamani

Western
Herminio L. Gamponia

Auxiliary

Ohio
Vicky Yost
*Donna Niess

Raleigh
**Pacita Salon

Residents

Sabrina D. Craigo

*Sustainer member **Extra-miler member

Obituaries

Woodrow W. Mills, M.D.

Woodrow W. Mills, M.D., of Kenova, W.Va., died September 19 in Cabell Huntington Hospital. He was 81.

Dr. Mills was born May 16, 1911, in Canterbury, W.Va., the son of the late Milton J. Mills and Eliza Adkins Mills. He graduated with honors from Marshall College in 1933 with an A.B. degree, and pursued a teaching career for seven years.

Dr. Mills studied medical education for two years at WVU and received his medical degree in 1943 from the Medical College of Virginia. He completed his internship in 1944 at St. Mary's Hospital in Huntington.

During World War II, Dr. Mills served in the U.S. Army Medical Corps. He returned from military duty in 1946 and set up his medical practice in family medicine. In 1951, he completed his residency in anesthesiology at the Hartford (Conn.) Hospital.

The West Virginia Chapter of the American Academy of Family Physicians recently honored Dr. Mills by selecting him to be the recipient of the 1992 Family Doc Award. A member of the WVSMA since 1947, Dr. Mills was also a member of the Cabell County Medical Society, the American Society of Anesthesiologists, the American Academy of Family Physicians and was a past president of the Norval Carter Memorial Medical Society. In addition, he was a member of American Legion Post 93 and the Kenova Chamber of Commerce.

Surviving is his wife, Thelma Hughes Mills; one daughter, Molly Ann Bevins of Huntington; three granddaughters, Jenny Thomas of Huntington, Roxanne Hagelstein of Holyoke, Mass., and Stephanie Hughes of Ashland, Ky.; seven grandsons, Kyle Gillen of Chesapeake, Ohio, Kirk Gillen and Kevin Gillen, both of Fort Lauderdale, Fla., Kent Gillen of Jacksonville, Fla., Thomas Sutherland of Omaha, Neb., Alex Sutherland of Charlotte, N.C., and John Sutherland of Raleigh, N.C.; one sister, Myrtle Virginia Troutman of Miami, Fla.; and one brother, M.J. Mills Jr. of Kenova.

Dr. Mills was preceded in death by his first wife, Faye Floyd Mills; three sisters, Armilda Allison, Florida Hedrick and Verna Staley.

Howard J. Maxwell, M.D.

Howard J. Maxwell, M.D., of Petersburg died October 23 at the Winchester (Va.) Medical Center. He was 68.

Dr. Maxwell graduated from Lost Creek High School and attended West Virginia Wesleyan College prior to joining the Army. He served in the 9th Army, 102 Infantry Division, 407th Infantry Regiment, 1st Battalion Medical Detachment, as an infantry medic with Company B, serving in the European Theater, (Normandy, France to the Elbe River, Germany) 1943-1946. During the occupation, he served as a staff sergeant responsible for the aid station. While in the service, Dr. Maxwell received the Bronze Star for bravery in combat, the Combat Medic Badge and the Good Conduct Medal.

Following his Army service, Dr. Maxwell earned A.B. and B.S. degrees from West Virginia University and enrolled in medical school there in 1948. Two years later, Dr. Maxwell entered the Medical College of Virginia in Richmond, Va., where he received his medical degree in 1952. After completing his medical education, joined the Veach-Townsend Clinic in 1954 and worked in the community for 38 years.

Dr. Maxwell served as a deacon of the Petersburg Presbyterian Church, president of the Potomac Valley Medical Society, and was chief of staff at Grant Memorial Hospital. He had been a member of the WVSMA since 1953 and had been a fellow in the American Academy of Family Physicians since 1958. Dr. Maxwell was also a member of the Sons of the American Revolution.

Dr. Maxwell served 11 years on the Grant County Board of Education and was appointed president for four years.

Surviving are his wife, Charlotte Christine Maxwell; three daughters, Dr. Mary Christine Maxwell-Young, Seattle, Wash., Johanna J. Kreyenbuhl, Berkeley Springs, and Martha K. Maxwell, Petersburg; one foster daughter, Pamela Susan Vetter, Winchester; two sons-in-law, Carl E. Kreyenbuhl and Ian D. Young.

THE MYERS CLINIC — Philippi, West Virginia

Notice: Seeking Internal Medicine, Pediatrics, and/or Family Practice, must be Board Certified or Board Eligible.

Also: Seeking Locum Tenen—Family Practice

Contact: Lonnie L. Crane, 112 North Woods Street, Philippi, WV 26416. 1-(304) 457-2800

Radiology:
Halberto G. Cruz, M. D.

Surgery:
J. W. Woodford, M. D.

Internal Medicine:
Karl J. Myers, Jr., M. D.
Z. Moussa, M. D.

Pathology:
Fulvio Franyutti, M. D.

Pediatrics:
E. G. Kreider, M. D.

West Virginia Medical Journal

ADVERTISING RATES

Full Page Color Advertisements:

Four Color, (back cover)	$925
Four Color, (inside back cover)	$825
Four Color, (inside)	$550
Spot Color	add $175

Black & White Advertisements:

Full Page, (inside front cover)	$450
Full Page, (inside back cover)	$450
Full Page, (back cover)	$450
Full Page, (inside)	$300

Ad Size	1x	3x	6x	12x
Color	$550	$525	$500	$475
Full Page B/W	$300	$275	$250	$200
1/2 Page	$175	$150	$125	$100
1/3 Page	$150	$125	$100	$ 80
1/6 Page	$125	$115	$100	$ 80

Sizes

Full Page	7 1/2" x 10"
1/2 Page (Horizontal)	7 1/2" x 4 3/4"
1/2 Page (Vertical)	3 1/2" x 10"
1/3 Page (Horizontal)	7 1/2" x 3 1/4"
1/3 Page (Vertical)	2 1/4" x 10"
1/6 Page (Vertical)	2 1/4" x 4 3/4"

Classified Ads

Each line measures 2 1/2 inches or 15 picas. The cost per line is $5. There is a minimum charge of $25 per ad. A discount of 10% is deducted for a six-time insertion.****

Subscription Rates

Single Copy	$3
United States	$36 per year
Foreign Countries	$60 per year

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA
MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article
The saga of rural health care 54

Scientific Newsfront
An epidemic of caterpillar sting dermatitis in a rural West Virginia community
Robert B. Walker, M.D.; Tim Thomas, M.D.; Dennis Cupit, MSIV; and Jennifer Giaquinto-Shreves, MSIII 58

Hypercoagulable states (Medical Grand Rounds from West Virginia University Health Sciences Center, Edited by Irma H. Ullrich, M.D.)
John S. Roger II, M.D. (Discussant) 61

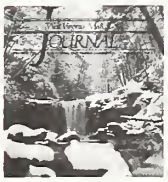
New Manuscript Guidelines 60

President's Page
The "T" word 64

Editorial
The Medical Community? 65

Our Readers Speak
State physicians deserve a level playing field 66

Departments
General News 68
Continuing Medical Education 72
Medical Meetings/Poetry Corner 73
Bureau of Public Health News 74
WVU Health Sciences Center News 76
MU School of Medicine News 78
Medical Student News 80
New Members/County Societies 82
Obituaries 83
Advertising Rates 84
Classified 85
February Advertisers 86



Front Cover

Beautiful snow-covered Marsh Fork Falls at Twin Falls State Park in Wyoming County. Photo courtesy of *Scott Durham* of Pineville, West Virginia.

The saga of rural health care

MAX A. HARNED, M.D.
Bruceton Mills, WV

In the days of the pioneers, one could hear the challenging cry, "Go West young man, go West." In the 1970s when I was in medical school, our instructors gave us a challenge -- "We need primary care physicians in rural areas. Go rural young (man/woman), go rural." So, with inspiration prevailing, I went rural.

Unfortunately though, I have had to accept the harsh fact that conditions are worse now for rural medicine than they were in 1983. How can this be when the great minds of Harvard and elsewhere said that they would be better?

The four main reasons why I believe rural medicine has become even more unattractive for physicians are:

1. My Medicare reimbursement was at least 10 to 20 percent less in January 1992 than it was in 1991. (No interpretation fees for EKGs and lowered biopsy and office visit fees, etc.)
2. Medicare requires the already overworked physicians to fill out information for Medicare billing on durable medical equipment. Physicians have already written a prescription for this equipment. Why can't the supplier of the durable medical equipment file their own form for reimbursement.
3. UPIN numbers are required for referrals, lab tests, etc.
4. Physicians' Office Labs (POLs) are discouraged. Is it easier for your patient to go over the mountain for lab testing? Can the doctor draw blood for $3 and cover all OSHA and other rules for hazardous wastes and personnel requirements? A physician in New York was fined $10,000 because he did not have a MSDS for vinegar.

Other disincentives for rural medicine include:

1. Office equipment repair costs are higher in rural areas. Travel time at $50-$100 per hour soon adds up.
2. Telephone expenses are more costly. Basic line charges are higher and there are more long-distance charges when calling patients and hospitals.
3. Fire insurance and other insurance is more expensive in rural areas. This is related to the proximity of fire and police departments.
4. Real estate values are less in rural areas (for example, health care clinics appraise less). Resale values are also less. Thus, some banks are reluctant to loan money for rural health projects. The same expenditures for materials and labor are appraised less. Therefore, your monthly payments may be more.
5. Professional personnel are difficult to attract and retain in rural areas since salaries are better in the cities.
6. Medical services provided by a physician for his relatives (parents, brother-in-law, etc.) cannot be billed to Medicare. This is a real problem for the physician who chooses to open a practice where he grew up. Their families may be glad to have them home, but they feel compelled to travel over the mountain for their medical care -- they don't like the idea that these physicians who are related aren't allowed to bill for their medical care. No co-insurance or supplemental insurance can be billed either since these companies want an EOMB from Medicare. If medical care to your family is not allowed, then deductibles do not accrue.

From the problems I have listed, one may conclude that virtually all the problems in medical practice and the economy are simply magnified in rural medicine.

Discussion about medical cost control often targets the cost of office calls and procedures; however, physicians have not been aided in controlling the cost of their expenses which relate to the price of services (i.e. malpractice insurance, office overhead, supply costs). Due to the fact that these items are not regulated, the cost of delivering care often is out of proportion to return (Cost of care = Price per Service x Volume or Number of Services). Government addresses the problem of "more demand than available service can provide" by having a waiting list (no license plates for three months). Perhaps medical care that has waiting lists will result if only one aspect of medical care is addressed -- the price of services.

The government still believes they can create something for nothing. Health care can be provided, but it is under cost. Government passes the laws, bureaucrats interpret the laws as they choose, and physicians are expected to carry out these policies as volunteers. Services are not a tangible product; therefore, the cost of production is not relative. In other words, "Doctor, your revenue will drop. We will pay you less for seeing a patient, but don't worry -- all you have to do is see more patients." Many of us are working too hard now. How many doctors must retire so they can exercise or follow their own advice (Doctor, heal thyself)?

If the private sector cannot provide this care under cost, then go to the public sector (socialized medicine). It doesn't matter that the quality of health care will decline. It took the

former U.S.S.R. 70 years to learn that Socialism does not work and I wonder how long it will take us? When will we recognize that the cost of services must be addressed and that limitation of services will have to be apparent for all (C = P x V)?

Considering our health care proposal for West Virginia, will every doctor write off $200 per patient? How much subsidy will that be? Will the state help us collect the co-payment or do we write it off also? When PEIA reduces reimbursement -- in some instances below what Medicare allows -- how long will services be provided by physicians? Workers' Compensation now asks for copies of your office notes plus endless reports. More hassle. Some physicians are limiting Workers' Compensation patients to one per week. Some people truly believe that government can deliver something for nothing and that health care is free.

Managed care is the buzzword. However, the best option for most business enterprises is for a private initiative. In Canada, physicians make more money per hour by offering services in their own homes after government hours. Russian farmers produce more per acre on private plots. Why not let private individuals choose their own health care system like the one proposed by the Heritage Foundation? Over six million federal government employees now participate in such a program. The individual's own dollars determine which health plan they choose. Money not spent for health care is given to the individual. If something is free and your own money is not spent for it, often overspending is the result.

Government regulations are so pervasive that some of my patients are frustrated. They can no longer mine coal (no permits, OSHA requirements, etc.). Big businesses hire consultants or go to seminars to cope with new regulations. I can't. Whenever the environment of medical practice or business benefits accountants, attorneys, and consultants more than the provider -- then the producer of goods and services has a dim future. Furthermore, it is difficult for us to enjoy our profession when our hands are tied and our everyday practice decisions are made by someone else, many of whom are outside of medicine. A nurse recently told me, "It (nursing) is no fun anymore; there is too much paperwork."

Our frustrations over the practice of medicine obviate various coping mechanisms, such as joining an HMO if there is one in your area; joining a "large group;" working in the emergency room; working for an insurance company; stopping hospital practice; or stopping hospital surgery. Some even take the plunge and do something else entirely different, such as growing pecan trees. In the future, will we see advertisements for "have doctor will travel"? Are we creating a system that selects only physicians that have very thick skins to cope with the barrage of external forces which drive us from practice? One must remember that with a thick skin also comes reduced sensitivity. I once saw a sign in a doctor's lounge located near a Medical Records Department that said: "It's not the long road ahead that wears you down -- it's the grain of sand in your shoe." From my sphere of medical practice, there is a lot of sand in my shoe.

Often physicians are accused of being pessimistic and thus discouraging other people from entering the profession. Is the eight-ounce glass half-empty or half-full? I try to see four ounces of fluid.

Someone said that West Virginia is being used as a model for health care reform. Why not? We have been USED for about everything else -- including how best to liquidate a health insurance company. Most people cast a ballot by making a mark with a pencil. Over 200 physicians in West Virginia made a mark with their feet.

Considering all of these problems, time is of the essence. A recent report by West Virginia University found that within 30 years, most West Virginians will be elderly. So will I. Who will take care of me, medically? -- Physician heal thyself?

Give all of us a level playing field and a rule book that promotes production. Give us legal reform and leadership that looks to all segments of society, not just what is better represented by special interest lobbies. We need a viable private sector. I, for one, do not want to work for the government, although our current tax system may dispute this.

Those of us in rural medicine are in the trenches. Like an earthquake, we are at the epicenter. The impact of health care policies are often seen first and the effects felt most in rural areas. If we are to address the saga of rural health care, then we must realize that physicians need to have a viable incentive to practice in these areas.

From the epicenters of rural medicine, hear our cries!

A delicate balance.

Everyone is a patient at one time or another. Vulnerable...dependent upon a nurse, a physician, a hospital. That's why we take our part in providing Major Medical, Term Life, and Disability Income coverage seriously. The key is to balance the quality and cost of healthcare practices. At McDonough Caperton, we take it upon ourselves to help physicians, clinics, and hospitals strike that delicate balance.

Call Us. 1-800-344-5139
Extension 708

McDonough Caperton Insurance Group

Service is the cornerstone of our business.

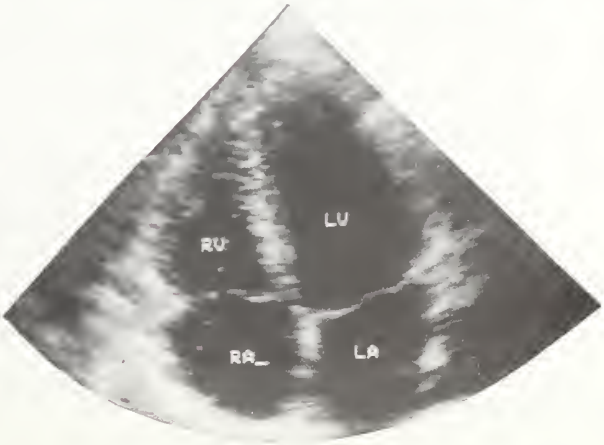
Corporate Headquarters One Hillcrest Drive, East, P.O. Box 1551, Charleston, WV 25326-1551, Telephone: (304) 346-0611 Fax: (304) 347-0697
With Offices Located in: Florida, Georgia, Kentucky, Ohio, Pennsylvania, Virginia, West Virginia and Bermuda

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time

sound



Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

An epidemic of caterpillar sting dermatitis in a rural West Virginia community

ROBERT B. WALKER, M.D.
Department of Family and Community Health, Marshall University School of Medicine, Huntington
TIM THOMAS, M.D.
Department of Family and Community Health, Marshall University School of Medicine, Huntington
DENNIS CUPIT, MSIV
Marshall University School of Medicine
JENNIFER GIAQUINTO-SHREVES, MSIII
West Virginia University School of Medicine

Abstract

During a five-week interval which began May 1991, 19 patients presented to a community health center in a rural West Virginia community with a painful dermatitis. The dermatitis was caused by exposure to a single species of caterpillar, Hemileuca maia, larva of the buck moth. The caterpillars were apparently especially abundant during the period. Epidemics of caterpillar stings rarely have been reported. No previous epidemics of stings by the buck moth caterpillar have appeared in the literature.

Introduction

Caterpillars are the larval stage of the order lepidoptera, class insecta and phylum arthropoda. Lepidoptera includes the moths and butterflies. While the vast majority of these creatures and their larvae are harmless to humans, a number of species among eight of the families found in North America have been reported to be truly venomous (1).

These caterpillars have tubular or porous hairs or spines which are filled with a venom produced by a unicellular gland at their base. The spines easily break off after penetrating the skin, allowing the venom to enter (2).

The species of venomous caterpillar most commonly described in the United States are *Megalopyge opercularis* (the puss caterpillar), *Automeris io* (the lo or corn emperor moth caterpillar), *Sibine stimulae* (the saddle-back caterpillar), and *Hemileuca maia* (the buck moth caterpillar).

Reactions to stings usually consist of local pain and swelling, sometimes severe. However, more serious reactions have been reported, including nausea, vomiting, lymphadenitis, shock and convulsions (3). Caterpillar stings have been confused with pit viper bites and hypersensitivity reactions to insect stings (4).

The chemistry and pharamacology of caterpillar venoms have been difficult to ascertain because of the difficulty in obtaining them in sufficient quantity and purity. Most venoms have been found to contain proteolytic enzymes, histamine or histamine-releasing substances. It is likely that venom components vary widely from species to species (3).

Treatment of caterpillar stings is essentially symptomatic and supportive. Systemic antihistamines have offered little relief of symptoms (5,6). Topical treatments have included lotions containing phenol or menthol and high potency corticosteroid creams. Systemic corticosteroids have been reported to be effective in relieving itching in puss caterpillar dermatitis (1). Removing retained hairs with repeated application and removal of adhesive tape is commonly recommended.

Stings usually occur sporadically from accidental exposure. Gardeners, construction workers, forestry workers and soldiers camped in wooded areas have been among victims described in case reports (7,8,9). Hunters, campers and picnickers may also experience incidental exposure (10).

Localized outbreaks of caterpillar stings within a community or region have rarely been reported. An extensive epidemic resulting from exposure to airborne larval debris was described in China in 1981 (11). Public schools in San Antonio, Texas, were closed in 1921 because of an

Table 1. Patient characteristics, stings by *Hemileuca maia*, Lincoln County, West Virginia, June-July 1991

	PT. #	AGE	SEX	LOCATION	CIRCUMSTANCES
5/31	1	4	M	R Foot	Stepped on caterpillar, petechia, erythema
5/30	2	5	M	L Ankle	Brushed against caterpillar, secondarily infected
6/5	3	2	F	L Foot	Stepped on caterpillar, lymphatic streaking
6/8	4	3	M	R Foot	Stepped on caterpillar, erythema, severe swelling, fever, enlarged lymph nodes
6/8	5	9	M	R Foot	Stepped on caterpillar
6/8	6	30	M	R Hand	Handled caterpillar
6/19	7	2	M	L Hand	Marked swelling w/streaking of hand
6/21	8	6	F	Both Feet	Stepped on caterpillar, stung 3 days in a row
6/23	9	5	M	L Foot	Stepped on caterpillar
6/23	10	7	F	Both Feet	Stepped on caterpillar, swelling, petechiae
6/24	11	2	F	L Foot	Stepped on caterpillar
6/25	12	12	M	R Foot	Stepped on caterpillar
6/27	13	67	M	R Hand	Handled caterpillar
6/28	14	26	F	R Hand	Handled caterpillar
6/28	15	39	M	R Ankle	Brushed against caterpillar
6/30	16	32	F	L Foot	Stepped on caterpillar
7/2	17	21	F	R Foot	Stepped on caterpillar
7/4	18	5	M	L Foot	Stepped on caterpillar
7/6	19	8	M	L Foot	Stepped on caterpillar

Figure 1. Foot of a four-year-old male following several stings by larva of *Hemileuca maia*. Note the linear pattern of vesicles and surrounding erythema. The extent of edema is noted by marker lines.

Figure 2. The larva of *Hemileuca maia*, the buck moth. Spikey bristles contain toxin. There is a distinctive pattern of linear, white dots on the caterpillar.

unusual abundance of the puss caterpillar, *Megalopyge opercularis* (12).

The epidemic

During a five-week interval beginning in June 1991, 19 patients presented to a rural community health center in Lincoln County, West Virginia, with an acute, painful vesicular dermatitis. Most of the patients were young children and the dermatitis was most commonly located on the plantar surface of the foot (Table 1). The dermatitis was ascribed to multiple stings from a single species of caterpillar, identified as the larva of *Hemileuca maia,* the buck moth.

The dermatitis, although transient, resulted in significant morbidity in terms of discomfort, restriction of activities of patients and their families, missed school days, and the cost and inconvenience of medical care. It is assumed that many unreported cases occurred within the community during the period. Although dermatitis from caterpillar stings is well described in the literature, cases of epidemics of such stings are rare.

This epidemic occurred between 5/31/91 and 7/6/91 within Lincoln County, which is located in the southwestern portion of the state and consists of densely forested, low hills. It is extremely rural, with only two incorporated cities, both with populations of less than 1,000. Cases included patients from all areas of Lincoln County.

The cases described are those presenting to a community-owned primary health care center, located just outside the county seat and largest city. The center provides much of the primary health care and most of the emergency services to the people of the area. The county has no hospital, and the closest emergency department is over an hour's drive away.

The index case was a four-year-old male, presenting with a painful rash and swelling of the foot of several days' duration. Physical examination revealed a dermatitis consisting of a series of clustered vesicles, arranged in linear patterns with surrounding ecchymosis and edema on the plantar surface of the foot. There was no fever, linear streaking or regional adenopathy (Figure 1).

The child's mother stated that he had stepped on a "black caterpillar" prior to the eruption. She also stated that such caterpillars were unusually numerous in the area.

During the following 36 days, 18 additional patients presented to the center with similar complaints and findings. All described a caterpillar as the offending agent. Several brought specimens with them which were later identified as the larva of *Hemileuca maia*. The typical case was a male child, age six or under, with a painful dermatitis on the plantar surface of the foot occurring after stepping on the caterpillar.

Several patients were adults who had handled the caterpillar or brushed against it. Several patients were febrile, developed tender inguinal adenopathy or extensive swelling. Two patients were stung on multiple occasions.

The insect *Hemileuca maia* is found within the United States from Maine to Wisconsin and south to Florida, Louisiana and Texas. The adult is commonly called the buck moth. It is one of the giant silkworm moths with a wingspan of 5 cm. to 7.5 cm. The wings are black with narrow white bands on fore wings and hind wings. The moths are most commonly seen in October, flying swiftly in forest clearings. The caterpillars hatch from overwintering egg masses starting in March. The tiny larvae feed in clusters or groups on developing leaves of various species of oak, especially the scrub oak, and willow (13). In years of population overgrowth, whole trees may be defoliated.

As the caterpillars grow, they molt about five times. The final molt occurs in May or June. The caterpillars have spines which protect them from predators and cause the painful stings in humans. Stings often occur when the larger caterpillars forage for food, migrate from tree branches and leaves to search for a final resting place on the ground, or are knocked or blown down.

The native caterpillar is about 6 cm. long. Its head is a deep reddish brown color, while the body is dull brown to black and covered with white to yellow dots. Numerous tufts of bristles or compound spines arise from each body segment (Figure 2). Once the caterpillars have reached the final molt stage in May or June, they construct a cell in the upper soil layers where they transform into a non-mobile pupa. In the fall around "buck season," the adult moths emerge and fly to the tops of trees to mate and lay eggs (14,15).

The caterpillar does not actively sting -- only when the spines break off in the skin does the dermatitis occur. Crawling on the skin is not harmful unless the insect is crushed.

Prevention of contact with the caterpillar involves the use of

protective footwear in infested areas, care in sitting down under trees, especially after stormy weather, and avoidance of the handling of caterpillars. Natural predators and diseases usually keep the population density low; however, outbreaks occasionally occur. These usually last for two to three years.

Discussion

An epidemic of localized dermatitis caused by caterpillar stings occurred in Lincoln County during the summer of 1991. Recognition of the epidemic may have resulted from either a true increase in the number of stings, or an increase in reporting. Discussions with health providers in the area resulted in no recollection of such a large number of stings in the past.

The epidemic occurred immediately following the emergence of 17-year cicadas in the area, but no association has been determined. It would be interesting to ascertain whether an increase in stings from *Hemileuca maia* or other stinging caterpillars occurred in other areas following emergence of periodical cicadas.

It is possible that the buck moth caterpillar is underestimated as a cause of painful stings. A report from Louisiana, while not describing an epidemic, listed *Hemileuca maia* as the most common cause of reported stings in that state (15).

Stings can be prevented by ensuring that children wear shoes when outdoors and by avoiding the handling of caterpillars. Treatment consists of removal of spines with adhesive, relief of symptoms and supportive care of the dermatitis.

Acknowledgements

The authors would like to gratefully acknowledge the invaluable help of Susan Joy, M.S., U.S. Corps of Army Engineers, and Charles Coffman, Ph.D., West Virginia Department of Agriculture, for their help in identifying the organism described in this article.

References

1. El-Mallakh RS, Baumgartner DL, Fares N. Sting of puss caterpillar, Megalopyge opercularis (Lepidoptera: Megalopyge): First report of cases from Florida and review of literature. J Fla Med Assoc 1986;73:521.

2. Harwood RF, James MT. Entomology in human and animal health. 17th ed. New York: Macmillan Publishing, 1979.

3. Rosen T. Caterpillar dermatitis; dermatologic clinics, 1990 Apr;8(2):245-52.

4. Daly J, Derrick BL. Puss caterpillar sting in Arkansas. South Med J 1975 July;68(7);893-4.

5. Hughes G, Rosen T. *Automeris io* (caterpillar) dermatitis. Cutis 1980;26:71.

6. Garty BZ, Danon YL. Processionary caterpillar dermatitis. Pediatr Dermatolo 1985;2:194.

7. Akhand AK. Caterpillar dermatitis. J Pakistan Med Assoc 1969;19:65.

8. Blair CP. The Browntail moth, its caterpillar and their rash. Clin Exp Dermatol 1979;4:415.

9. Press E, Googins JA, Poareo H, et al. Health hazards to timber and forestry workers from the Douglas fir tussock moth. Arch Environ Health 1977;32:206.

10. deJong MC, Hoedemaeker PJ, Jongebloed WL, et al. Investigative studies of the dermatitis caused by the larva of the browntail moth (*Euproctis chrysorrhea*). In: Clinical and experimental findings. Arch Dermatol Res 1975;253:286.

11. De-Long S. Mullberry tussock moth dermatitis. J Epidemiol Comm Health 1981;35:1.

12. Pinson RT, Morgan JA. Envenomation by the puss caterpillar *Megalopyge opercularis*. Ann of Emergency Medicine 1991 May;20:5,126-8.

13. Ferguson CF. *The moths of North America: Bombycoidea: Saturnidae*. London: E.W. Classey Limited and R.B.D. Publications, 1972.

14. Pest Alert: United States Department of Agriculture Forest Service. Buck Moth.

15. Goyer R. Fact Sheet - The Buck Moth. Louisiana Agricultural Experiment Station; 1989 March.

New Manuscript Guidelines

All scientific manuscripts should be submitted on disc in the following languages: Wordperfect 4.2, 5.0, and 5.1; Word; Word for Windows; and WordStar. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

No more than 25 references will be published free of charge and they must be presented in the style based on the formats used by the U.S. National Library of Medicine in *"Index Medicus."*

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Medical Grand Rounds

West Virginia University Health Sciences Center

Edited by Irma H. Ullrich, M.D., Professor of Medicine, Section of Endocrinology and Metabolism

Hypercoagulable states

Discussant:
JOHN S. ROGERS II, M.D.
Professor of Medicine, Section of Hematology/Oncology

Abstract

A hypercoagulable state is an enhanced tendency to form venous or arterial thrombi. In 1845, Virchow postulated three factors responsible for thrombosis that remain relevant today: alterations of the blood (hypercoagulability); changes in vessel wall (vascular injury); and impairment of blood flow (stasis). An increased understanding of the molecular basis of thrombosis has been aided by the identification of individuals with specific inherited defects in the natural anticoagulation system. These primary hypercoagulable states include antithrombin III, protein C and protein S deficiencies, dysfibrinogenemias, plasminogen deficiency, and decreased plasminogen activator activity. Individuals with thrombosis at an early age, a family history of thromboembolic disease, unusual sites of thrombosis, or recurrent thrombosis without apparent cause should be evaluated for a primary hypercoagulable defect. The majority of patients do not have a recognizable specific defect. However, there are a variety of underlying conditions or diseases that are associated with an increased risk for thrombosis. The etiologies of secondary hypercoagulable states are often unclear and may be multifactorial. Treatment of these inciting conditions or diseases may decrease the thrombotic tendency.

Pathophysiology

Venous thrombosis is a common event with pulmonary emboli causing 200,000 deaths a year in the United States (1). Considerable further morbidity and mortality is produced by thromboembolic events associated with coronary artery, cerebrovascular and peripheral vascular diseases.

In 1845, a young German pathologist named Rudolf Virchow presented a then novel concept of the pathogenesis of thromboembolic disease which remains useful today (2,3). Virchow described three factors causing thrombosis: alterations of the blood (hypercoagulability); changes in the vessel wall (vascular injury); impairment of blood flow (stasis) (Figure 1).

Impairment of normal blood flow (stasis) allows accumulation of procoagulant substances and facilitates platelet-vessel wall interaction with promotion of thrombus formation. More severe stasis may be associated with acidosis and endothelial hypoxia leading to vascular injury. Stasis along with alterations in the blood (hypercoagulability) play important roles in venous thrombosis. The venous system is a low pressure, low flow, high capacity system that is more susceptible to stasis. In contrast, the arterial system is less affected by stasis and more affected by vascular injury and hypercoagulable changes in the blood.

Figure 2 illustrates how an intact endothelium protects against thrombosis in at least four ways:

1. The endothelial surface expresses thrombomodulin receptors which serve to bind thrombin and change its configuration to allow thrombin to activate protein C. Activated protein C in conjunction with its co-factor protein S inactivates factors Va and VIIIa. Thrombin bound to thrombomodulin is no longer available to activate fibrinogen or promote platelet aggregation.
2. Thrombin activates endothelial production of prostacyclin, an inhibitor of platelet aggregation.
3. Heparin-like proteoglycans on the endothelial surface promote inactivation of thrombin by antithrombin III.

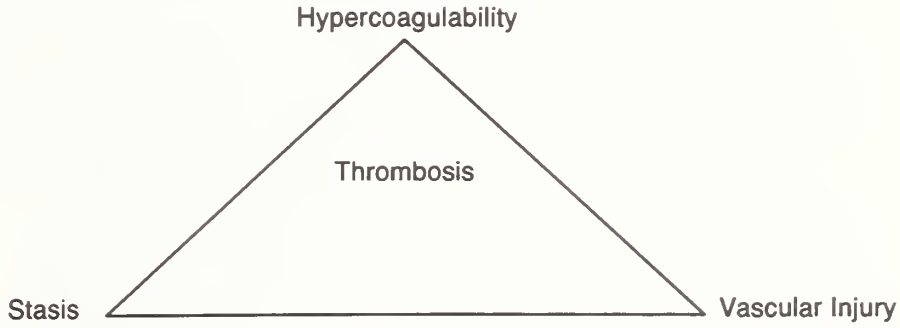


Figure 1. Virchow's triad- factors causing thrombosis.

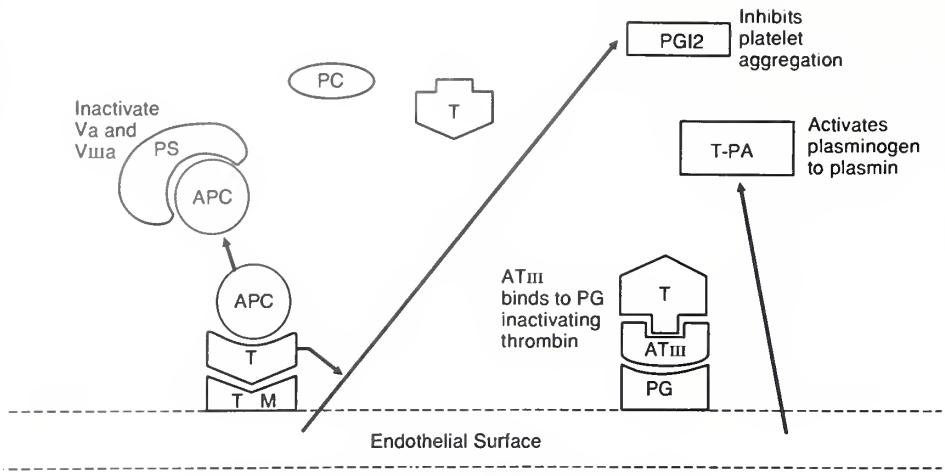


Figure 2. Antithromobotic properties of endothelial surface (see text). Abreviations: T, thrombin; TM, thrombomodulin; PC, protein C; APC, activated protein C; PS, protein S; Va and VIIIa, activated factors Va and VIIIa; PGI2, prostacyclin; PG, heparin-like proteoglycans; ATIII, antithrombin III; T-PA, tissue-type plasminogen activator.

4. Tissue-type plasminogen activator is produced by endothelial cells with subsequent activation of plasminogen to plasmin resulting in lysis of fibrin clots, an important limiting factor in thrombus formation.

Vascular injury exposes subendothelial components such as collagen and tissue factors initiating platelet adhesion and aggregation as well as fibrin clot formation. Inflammatory mediators such as endotoxin, interleukin-1 and tumor necrosis factor promote thrombosis through endothelial surface expression of tissue factor and down regulation of thrombomodulin receptors (4). Inherited hypercoagulable states have been described with specific defects in the natural anticoagulants antithrombin III, protein C, protein S, and the plasminogen-plasminogen activator system as well as with abnormal fibrinogens (1,3,4,5,6).

Primary hypercoagulable states

An increased understanding of thrombus formation and the hypercoagulable state has been gained by identification of specific inherited defects in the natural anticoagulant system. However, most individuals with thromboembolic events do not have a known inherited defect; only 10 to 20 percent of young persons with thrombosis have an identifiable defect (5).

Antithrombin III, an important regulator of coagulation, inactivates thrombin as well as activated factors IXa, Xa and XIIa. Antithrombin III deficiency is inherited in an autosomal dominant pattern with an incidence of one in 2,000 to 5,000 (5,7). Affected heterozygotes have plasma levels between 25 to 60 percent (normal range 80 to 120 percent) with 55 percent of these individuals developing thrombotic events, usually by age 30. Deficiencies may be due either to reduced synthesis (type I), or to functional defects (type II). Decreased plasma antithrombin III levels are seen with heparin therapy, pregnancy, liver disease, extensive thrombosis, intravascular coagulation, and nephrotic syndrome. Warfarin therapy increases plasma antithrombin III levels.

Protein C, a vitamin K-dependent plasma protein, inactivates factors Va and VIIIa. Inherited deficiencies of plasma protein C have been described in five to eight percent of individuals with idiopathic venous thrombosis (4). Heterozygotes have plasma levels less than 55 percent (normal range 70 to 140 percent) with 75 percent of the affected individuals having one or more thrombotic events (5,8). Most commonly, decreased plasma protein C is due to decreased synthesis (type I), but functional defects (type II) also occur. Homozygous deficiencies of protein C are associated with less than one percent normal plasma levels and intravascular coagulation with purpura fulminans in the newborn, which is a fatal condition without protein C replacement. Initiation of warfarin therapy may occasionally be associated with coumarin-induced skin necrosis due to fibrin thrombi in cutaneous vessels. This event is due to a decrease in plasma protein C, a vitamin K-dependent protein. Up to one-third of these cases occur in persons with congenital protein C deficiency. Decreases in plasma protein C are also seen in patients following surgery or warfarin therapy, or in individuals with liver disease, intravascular coagulation, acute respiratory distress syndrome, and warfarin therapy.

Protein S, the vitamin K-dependent co-factor for protein C, exists in plasma 40 percent in the free (active form) and 60 percent bound to C4b-binding protein (inactive form). Heterozygous protein S deficiency has been described in five to eight percent of individuals with idiopathic venous thrombosis (4). A decrease in total and free protein S to 50 and 40 percent of normal, respectively, has been described with classic inherited protein S deficiency. Patients have been also described with normal total protein S values, but with decreased plasma-free protein S. Most of protein S was bound to C4b-binding protein (9). Plasma levels of protein S are decreased with pregnancy, estrogens, intravascular coagulation, acute thromboembolic disease, warfarin, and liver disease. Of interest, C4b-binding protein is an acute-phase protein. Increases in C4b-binding protein with inflammation result in decreased plasma-free protein S.

Inherited abnormalities of fibrinogen (dysfibrinogenemias) produce fibrin resistant to fibrinolysis. Fewer than 20 cases of dysfibrinogenemias associated with venous thrombosis have been reported (5,6). Cases detected to date have had prolonged thrombin times with normal or mildly decreased fibrinogen levels.

Plasminogen is activated to plasmin by tissue-type plasminogen activator, t-PA. Plasmin, in turn, lyzes fibrinogen and fibrin. Perhaps 10 cases of inherited quantitative or qualitative abnormalities of plasminogen have been associated with thromboembolic events (5). A few families have been reported who have decreased endothelial release of plasminogen activator or high plasma levels of

plasminogen activator inhibitor (5,6). Of interest is the fact that either decreased endothelial release of plasminogen activator or elevated plasma plasminogen activator inhibitor levels have been noted in up to one-third of patients with venous thromboembolism (5). Interpreting results of plasma assays for fibrinolytic activity, i.e., plasminogen activator and plasminogen activator inhibitor, is complicated by considerable overlap between patient and normal values and the fact that plasminogen activator inhibitor is an acute-phase protein.

Management of hypercoagulable states

Patients with primary hypercoagulable states have specific measurable defects, but their occurrence is uncommon. Individuals with thrombosis at an early age, a family history of thromboembolic disease, unusual sites of thrombosis (axillary vein, hepatic/mesenteric vein, arterial thrombosis), or recurrent thrombosis without apparent cause, should be evaluated for one of these defects. Functional and immunologic assays for antithrombin III and protein C, total and free protein S immunoassays, fibrinogen level, thrombin time, and functional plasminogen level should be obtained. The clinical usefulness of currently available assays for plasminogen activator and plasminogen activator inhibitor remains to be established. Patients should have ceased anticoagulants for seven to 10 days before testing. Family members of individuals with primary hypercoagulable defects should be evaluated, both to confirm the original diagnosis and to identify other members at risk for thromboembolic events.

Individuals with primary hypercoagulable states should receive prophylactic anticoagulation for surgical, obstetric or medical situations that are associated with increased risks of thrombosis. When available, replacement therapy with specific concentrates should be considered. Patients with two or more spontaneous thromboembolic events are candidates for long-term anticoagulation. Decisions regarding chronic warfarin therapy should include consideration of the severity of thrombotic events in the patient and other family members, whether events were spontaneous or involved precipitating factors, plans for childbearing in women, and occupation or lifestyle factors that might either increase the risks for thromboembolic events or bleeding complications.

Since testing for specific anticoagulant defects is expensive and unrewarding in most patients with thromboembolic events, global screening tests to detect either patients with an increased risk of thrombosis or the presence of active thrombosis would be useful. Unfortunately, currently available screening tests lack sufficient sensitivity and specificity. Markers of in vivo thrombin activation include plasma prothrombin fragment F1.2, which is released when prothrombin is cleaved to thrombin by factor Xa. Fibrinopeptide A is released when fibrinogen is cleaved to fibrin by thrombin. Plasma F1.2, but not fibrinopeptide A levels, are increased in individuals with congenital antithrombin III and protein C deficiencies. However, there is considerable overlap in plasma F1.2 levels between normal individuals and persons with antithrombin III or protein C deficiencies. Plasma F1.2 and fibrin fragment D dimer, formed with plasmin lysis of fibrin, are increased in individuals with acute thromboembolism. A plasma level of D dimer less than 200 ug./L essentially rules out an acute thromboembolic event with a predictive value of 98-100 percent (1). D dimer levels lack specificity, however, due to the fact that numerous diseases can elevate plasma D dimer levels.

Secondary states

A variety of underlying conditions or diseases are associated with an increased risk for thromboembolic events. The etiologies of these acquired or secondary hypercoagulable states are often unclear and may be multifactorial. Treatment of the underlying condition or disease may decrease the thrombotic tendency.

The lupus anticoagulant is identified by prolongation of phospholipid-dependent clotting assays such as the activated partial thromboplastin time or kaolin clotting time (10). It is present in one to two percent of the general population and 25 to 50 percent of patients with systemic lupus erythematosis. The lupus anticoagulant is associated with increased risk of arterial and venous thrombosis, and habitual abortions (5). Most patients have co-existent anticardiolipin antibodies which are suspected by biologic false-positive VDRL test and more accurately identified and quantitated by ELISA assay (10). The mechanism of the associated thrombotic complications is unclear.

Other examples of secondary hypercoagulable states include malignancy, pregnancy, oral contraceptive use, nephrotic syndrome, myeloproliferative disorders, paroxysmal nocturnal hemoglobinuria, hyperlipidemia, diabetes mellitus, conditions promoting stasis (immobilization, obesity, advanced age, postoperative state), artificial surfaces such as indwelling venous catheters, and hyperviscosity (polycythemia, sickle cell disease, increased serum viscosity). An excellent review by Shafer is recommended for a more complete discussion of secondary hypercoagulable states (6).

References

1. Sane DS, Greenberg CS. Laboratory studies in venous thrombosis and fibrinolytic therapy. In: Koepke JA, editor. Practical laboratory hematology. New York: Churchill Livingstone, 1991:395-407.

2. Brinkhous KM. The problem in perspective. In: Sherry S, Brinkhous KM, Genton E, Stengle JM, editors. Conference on thrombosis. Washington, D.C.: National Academy of Sciences; 1969:335-8.

3. Joist JH. Hypercoagulability: introduction and perspective. Semin Thromb Hemost 1990;16:151-7.

4. Comp PC. Overview of the hypercoagulable states. Semin Thromb Hemost 1990;16:158-61.

5. Bauer KA. Pathobiology of the hypercoagulable state: clinical features, laboratory evaluation, and management. In: Hoffmen R, Benz EJ, Shattil SJ, Furie B, Cohen HJ, editors. Hematology. New York: Churchill Livingstone, 1991:1415-30.

6. Shafer AI. The hypercoagulable states. Ann Intern Med 1985; 102:814-28.

7. Tollefsen DM. Laboratory diagnosis of antithrombin and heparin cofactor II deficiency. Semin Thromb Hemost 1990;16:162-8.

8. Miletich JP. Laboratory diagnosis of protein C deficiency. Semin Thromb Hemost 1990;16:169-76.

9. Comp PC. Laboratory evaluation of protein S status. Semin Thromb Hemost 1990;16:177-81.

10. Triplett DA. Laboratory diagnosis of lupus anticoagulants. Semin Thromb Hemost 1990;16:182-92.

President's Page

Robert P. Pulliam MD.

The "T" word

TAX – A charge, usually of money, imposed by an authority upon persons or property for public purposes.

It's usually easy to identify a tax because often it's preceded by an adjective like income, social security, unemployment, property, sales, etc. Increasingly, however, government with its insatiable desire for funds, is eliminating the adjective or changing the name so that the public doesn't see the word tax.

Physicians should carefully review the following table taken directly from an explanation of benefits provided by a Health Economics Corporation claims processor for their Public Employees Insurance Agency.

Note the charge of $150.00 and PEIA eligible expense of $138.23. The $11.77 difference is labeled a "discount" -- oops a tax. But we're not finished -- now observe the withheld of $5.53, an additional tax -- oops a withheld.

Thus, PEIA has capriciously not only set the fee the provider can charge, but further reduced that fee by the "withheld." The withheld varies from time to time based on the states' need for funds.

Where else in society is the cost or fee decided by the purchaser; especially after the fact of the purchase. Can the "discount" and the "withheld" be viewed in any other reasonable way except as a TAX. Furthermore, providers are prohibited from billing the patient for either the discount or the withheld.

Providers thus are taxed by providing services for which they are not compensated. The estimated amount of this tax contribution exceeds $25,000,000 annually, an amount contributed by physicians not provided by the state.

West Virginia's constitution provides an "Equal And Uniform Tax Clause;" a clause whose provisions were virtually the "raison d'etre" for the creation of this state. The concern that people should bear the expense of government in some equal and predictable fashion is long-standing and firmly entrenched in our society.

Physicians beware! The "T" word is again in the coming session of the Legislature, and this time it has an adjective -- provider tax.

Robert P. Pulliam, M.D.

BENEFIT CALCULATIONS

DATES FROM TO	TOTAL CHARGES	DIS-ALLOWED	SEE MEMO	DISCOUNT	ELIG EXPENSE	DEDUCT APPLIED	PLAN BENEFIT
11/25 - 11/25/92	150.00	0.00	P3	* 11.77	138.23	0.00	110
TOTALS	150.00	0.00		11.77	138.23	0.00	110

COB / ADJUSTMENT

TOTAL COVERED:	$	138.23
EMPLOYEE SHARE:	$	27.65
OTHER COVERAGE:	$	0.00
ADJUSTMENT(S):	$	0.00
WITHHELD:	$	5.53
TOTAL BENEFIT:	$	105.05

The Medical Community?

It was right after the paragraph in the news story describing how President Clinton marked the 20th anniversary of the Supreme Court decision legalizing abortion that the important part came. He had eliminated the ban on restricting abortion counseling at government-supported health care sites and halted the ban on using fetal tissue for research. He also gave permission for abortions at military hospitals and promised to review the ban on an abortion pill manufactured in France.

The important part of the AP story read, "The actions were cheered by the medical community and abortion rights advocates alike." Now, I know I didn't cheer anything like that. The AMA I'm sure, wouldn't dare cheer anything like that, nor the medical association of this or any other state, nor any county medical society I have ever heard of.

Without a doubt, there were some individual doctors who might have wanted to cheer this news and perhaps there are even some abortion rights advocacy groups whose membership is made up of physicians that might have wanted to lead organized cheers. None of these were named. The news account simply said, "The actions were cheered by the medical community . . ."

Something very important has been stolen from each of us when someone can report our individual and group opinions on any side of an issue without even consulting us. It is simply an out and out lie that the "medical community" cheered anything.

Perhaps it is our fault that some reporter can assume the authority to delegate to himself or herself the right to form and report the opinions of the medical community. We have been unwilling to express ourselves at any length as individuals or as groups on the subject of abortion for fear of splintering our professional organizations over an issue about which we are split at least to the extent that the remainder of the United States population is split on it. The AMA has been straddling the fence on abortion for decades with a policy that says essentially, "Where abortion is legal, it is ethical; where it is illegal, it is unethical."

We suspect that there are strong feelings to be expressed on the subject on the side of the Pros and on the sides of the Cons. We believe it will be less damaging to us and our professional organizations to duke out our differences than, by our silence, to allow others the opportunity to dictate and record what our opinions might be.

To this end, we promise to publish any comments our literate members or their literate spokespersons might want to make on abortion or any other controversial subject. We will place these letters and comments in the *Journal* sections entitled Our Readers Speak and In My Opinion.

So, express your opinions. Media propagandists, all too eager and willing to tell us our opinions, are out there waiting for the opportunity. We cannot afford to tolerate that.

– SDW

State physicians deserve a level playing field

The primary care scholarship system proposed by Dr. Wallace D. Johnson of Beckley is an extremely good idea. This type of plan has been kicked around in various forms over the past several years, but nothing positive has been done. Combined with this primary scholarship plan, though, should be the requirement that West Virginia physicians be paid the same amount of money for the same amount of care as given by their counterparts in all other states.

For some bizarre reason, the federal government has a geographical factor in their payment of federal workers in various states. As you can readily imagine, West Virginian physicians are paid less for the same amount of work than doctors in any one of the surrounding states. For the treatment of Medicare patients, this amounted to 30 percent less payment for orthopedic patients in the state of West Virginia as compared to the state of Ohio. It also meant 26 percent less payment for physicians in the state of West Virginia than in the state of Pennsylvania.

Before some critic screams out that the doctors in West Virginia simply want more money, let me point out that I am not asking for more money. I am asking for a level playing field. It would go a long way toward paying off the federal debt if all physicians in the United States were paid the same amount as the physicians in West Virginia.

I would also like to see a letter in the *Journal* as to how these geographical factors affect the pay scale of U.S. senators or congressmen (I believe that there is no geographical factor). I would also like to find out if this geographical factor applies to federal judges (I do not believe it does). I would also like to see if this applies to federal workers in the postal system and in the other federal programs such as the FBI (I believe that it does).

I do not believe that any proposed system will ever help improve medical care in underserved communities until we have a level playing field where payment is concerned. As long as the federal government is willing to pay physicians in all the surrounding states a greater amount of money for the same amount of work, the federal government is literally enticing physicians away from this state.

It certainly would be nice if our elected U.S. senators and congressmen would address this problem.

James H. Wiley, M.D.
Morgantown

WESPAC

West Virginia State Medical Association's
Political Action Committee

With so many challenges facing organized medicine, it is imperative that we have support in the Legislature. The need for political action has never been greater!

Write your personal check to WESPAC today and help us strengthen our role in the legislative process.

$50 - Regular **$100 - Sustainer**
$150 - Extra Miler

Mail your personal check to:

WESPAC
P.O. Box 4106
Charleston, WV 25364

WVAAFP 41st assembly set for Morgantown

The 41st Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians will take place April 16-18 at the Lakeview Resort in Morgantown, with special preconference events on April 15.

This year's first preconference seminar, "Laboratory Quality Assurance for Better Patient Care," will begin at 8 a.m. and adjourn at 4 p.m. on April 15. The 12th Annual Golf Tournament will tee off at 1 p.m. and then, at 4:30 p.m., Harold Preston, vice president of Physicians Practice Management, and Steve Greer, president of Integrated Computer Systems, will conduct a two-hour electronic coding and billing seminar.

On Friday morning, the conference will officially kickoff at 7 a.m. with a continental breakfast and registration. The first session, "New Strategies in Smoking Cessation and Nicotine Dependence," will then begin at 8:25 a.m. This panel discussion will include presentations by Joseph Golish, M.D., of the Cleveland Clinic; Maxine Stitzer, Ph.D., of Johns Hopkins University School of Medicine; Elbert Glover, Ph.D., of WVU; and Saul Shiffman, Ph.D., of the University of Pittsburgh. The morning's events will conclude with a lecture entitled "Medical Management of Benign Prostatic Hypertrophy" by Robert Bahnson, M.D., of the University of Pittsburgh.

Friday's presentations will reconvene after lunch with a panel discussion on "Negotiating and Contracting with Managed Health Care Plans: Pitfalls and Opportunities." Featured speakers will be David Vogel, of David Vogel & Associates, Inc. of Albuquerque, N.M., who will also serve as one of the moderators; Arthur Lerner, J.D., of Michaels & Wishner in Washington, D.C.; and Donald Schaller, M.D., of the Samaritan Foundation in Phoenix, Ariz. The day's activities will end with alumni and all member parties.

Registration and a continental breakfast will again start at 7 a.m. on Saturday. A breakfast for women in family medicine is set for 7:15 a.m., followed by the day's first scientific session, "Emotional Aspects of Cancer," by Carol Alter, M.D. The other scheduled presentations that morning will be "Dematology for the Family Physician," by Robert Brodell, M.D., of Brodell Medical Inc., in Warren, Ohio; "Chronic Fatigue Syndrome in Children," by David Bell, M.D., of Cambridge Hospital in Cambridge, Mass.; and "Fibromyositis" by Anthony DiBartolomeo, M.D., of WVU.

Glover

Brodell

Bell

In the afternoon, Joseph Ornato, M.D., of the Medical College of Virginia, will deliver the lecture "The Acute MI - The First Critical Minutes" at 1:30 p.m. Also scheduled are the presentations "Alcohol and Prescription Drug Abuse," by Sidney Schnoll, M.D., Ph.D.; and "CQI As It Relates to a Green Family's Diagnosis," by Jack Lord, M.D. After these lectures, a cocktail party, the annual banquet, and an after dinner dessert/cordial party are planned.

Sunday's activities will begin at 7 a.m. with complimentary SMAC-20s by SVI and proceed with a panel discussion on "Antibiotic Dynamics in Cells and Tissues." Speakers will be Bruce Woolley, Pharm D., of Provo, Utah; and Richard Greenberg, M.D., of the University of Kentucky. The meeting will then conclude at noon following "Therapeutic Considerations for the Management of Respiratory Tract Infections," by Domenic Gaziano, M.D., of Charleston; and "Future Effects of the NHLBI Recommendations on Physician Practice and Treatment of Asthma," by Michael A. Kaliner, M.D., of the NIH.

The program has been reviewed and is acceptable for 22.50 prescribed hours by the AAFP and for 22.50 hours toward the AMA's Physician's Recognition Award. AOA credit towards category 2-A for 22.50 hours is also approved.

For more details and registration information, contact the WVAAFP at 776-1178.

Register early for Annual Meeting!

This year's WVSMA Annual Meeting will again be conducted during the same week as the West Virginia State Fair, so it is important that participants who wish to stay at The Greenbrier phone the hotel at 1-800-624-6070 as soon as possible for reservations.

Please see page 71 for a registration form for the meeting, and contact the WVSMA at 925-0342 for more information about other area hotels.

Acute puncture wounds subject of WVU statewide study

Around March 15, Drs. Ward and Blaha of the Orthopedics Department at West Virginia University are planning to initiate a prospective, randomized study at 14 hospitals in the state to investigate management of acute puncture wounds to the foot. Goals of the study are to determine the most appropriate wound management, evaluate cost-effectiveness of routine radiographs and establish prospectively the incidence of infection with and without use of antibiotics.

The first step in the project was a questionnaire concerning acute puncture wounds to the foot that Drs. Ward and Blaha mailed to emergency care personnel at the 51 hospitals in West Virginia that have 24-hour emergency departments. Forty-four institutions completed the questionnaires for an 86 percent response rate. Data from the questionnaires showed considerable variability in the care delivered as well as in the cost of treatments.

The hospitals that have agreed to participate are Beckley, Cabell Huntington, Charleston Area Medical Center, City Hospital of Martinsburg, Humana Hospital at Greenbrier, Logan General, Monongalia General, Ohio Valley Medical Center, Raleigh General, Ruby Memorial, St. Mary's, Thomas Memorial, United Hospital Center and Wheeling Hospital. The cooperation and interest of these hospitals will make an enormous contribution to the success of this potentially landmark investigation.

For more information about the study, call Drs. Ward or Blaha at 293-3908.

Eastern Virginia schedules CME programs for 1993

The Eastern Virginia Medical School Office of Continuing Medical Education has announced eight CME courses for 1993.

The first program "Laboratory Workshop in Breast Reconstruction," is planned for March 25-27 at the Sentara Norfolk General Hospital in Norfolk, Va.

For more information about this seminar and the other future CME events, contact the EVMS-CME office at (800) 446-6140.

WVSMA members hosting TV shows

D'Alessandri

Pait

Dr. Robert M. D'Alessandri, dean of the WVU School of Medicine and vice president for health sciences, and Dr. T. Glenn Pait, assistant professor of neurosurgery at WVU, are both moderating a weekly health-related talk show called "Doctors On Call," which is being aired by WNPB, Morgantown's public TV station.

The show is broadcast live each Thursday from 8 p.m. - 8:30 p.m. and features WVU HSC faculty members discussing a variety of health-related issues. Viewers can call 293-6516 or 1-800-359-6111 with questions.

In addition, Dr. D'Alessandri is also hosting a new weekly health segment during the 6 p.m. news broadcast on WDTV in Clarksburg, and he is continuing to moderate a weekly health series during the 6 p.m. news on WCHS-TV in Charleston.

AABB to present two conferences in March

The American Association of Blood Banks will be sponsoring a workshop entitled "Stem Cell and Marrow Processing for Transplantation: Review and Update" on March 7 in Tampa, Fla.; and will be presenting "Immunohematology Reference Laboratory Conference" on March 20-21 in Peachtree City, Ga.

The first conference will cover all aspects of progenitor processing, including collection of marrow, peripheral blood and cord blood progenitors; positive selection of progenitors; purging of malignant cells and T cells; cryopreservation; storage; and quality assurance. The second program will be devoted to the technical and administrative issues vital to the key functions of a state-of-the-art reference laboratory and was planned by the AABB and the American Red Cross.

For more details about these meetings, contact the AABB Education Department at (301) 215-6482.

AMA offering seven practice seminars

To assist physicians and their office staffs with the various aspects of managing a medical practice, the AMA has scheduled seven different workshops at cities throughout the United States.

A two-day seminar entitled "Starting to Practice Smart," will be offered in New York on February 26-27, and then be held at locations in Chicago, Boston, Los Angeles, Chicago, Washington, D.C., Santa Fe, Houston, Chicago, and Ann Arbor, Mich., until the end of June. On the days prior to this seminar in these cities, a half-day workshop will be conducted on "Joining a Partnership or Group Practice."

In addition, half-day seminars on "Personnel Principles: Building a Practice Team," and "Quality Service: Positive Relationships for Patients and Staff," are being held in many of the cities previously mentioned, as well as in other sites such as Oklahoma City, San Francisco and Orlando. On the days immediately following these seminars in all the locations, full-day workshops will be presented on the subjects of "Billing and Collecting in a Medical Practice," "CPT Coding for Doctors' Offices," and "ICD-9 Coding for Doctors' Offices."

For more details, call 1-800-366-6968. Special travel assistance is available through ITS by phoning 1-800-621-1083.

University of Maryland presenting infectious diseases symposium

The Division of Infectious Diseases of the University of Maryland School of Medicine is sponsoring a two-day symposium at the Baltimore Convention Center-Inner Harbour on April 19-20.

This seminar is designed to provide clinicians with updates on emerging syndromes, newly recognized organisms, the HIV epidemic, new antibiotic therapies, antibiotic-resistant organisms, and points about managing a variety of infectious diseases. The program has been approved for 12.75 credit hours in Category I of the AMA's Physician Recognition Award; 12.5 prescribed hours by the American Academy of Family Physicians; and 1.27 CEU's (12.7 contact hours by the American Nurses Credentialing Center's Commission on Accreditation.

For information, phone Eunice Katz at (410) 706-7560.

WVACP announces award-winning papers, fellowships

At the Scientific Meeting of the West Virginia Chapter of the American College of Physicians which was held in Charleston recently in conjunction with the WVSMA's Mid-Winter Clinical Conference, 37 associates presented papers and eight were awarded prizes.

The award winners and their papers were Ahmad J. Qarqash, M.D., "Emphysematous Gastritis;" Pradipta Chaudhuri, M.D., Pseudomelanosis Duodeni;" Mohammad Akbar, M.D., "A Case of Blastomycosis in the Northern Panhandle;" Paul J. Marks, M.D., "Paradoxical Vocal Cord Disorder Mimicking Severe Asthma;" F. Matthew Abraham, M.D., "Primary Non-Hodgkins Lymphoma of the Spleen with Thrombocytopenia;" Daniel Macias, M.D., "Thyroid Lymphoma in Patients with Pre-Existing Autoimmune Thyroiditis;" David A. Law, M.D., "Mycobacterium Kansasii Tenosynovitis in an Immunocompetent Host; and Deborah Blumenthal, M.D., "Gram-Negative Bacillary Meningitis in Adults."

In addition, Robert J. Marshall, M.D., F.A.C.P., governor of the WVACP, has announced that six physicians have been elected to fellowship in the American College of Physicians. The new fellows are Steven A. Artz, Charleston; Gurpreet S. Brar, Parkersburg; Charles R. Honaker, Parkersburg; Jeffrey L. Meely, Morgantown; Mohammad Roidad, Fairmont; and Stephen N. Smith, Buckhannon.

Kidney research grants available

Baxter Healthcare Corporation awards $3 million annually to kidney researchers worldwide and the deadline for its next round of grants is April 9.

The April 9 research topics are (1) Lipids in Renal Disease and 2) Peritoneal Dialysis in the Pediatric Patient.

For more information about Baxter's grants, contact Lee Henderson, M.D., F.A.C.P., at (708) 270-5200.

WVACS spring convention set for April 29-May 1

This year's Annual Spring Meeting for the West Virginia Chapter of the American College of Surgeons is scheduled for April 29-May 1 at The Greenbrier in White Sulphur Springs.

Guest speakers for this event include Louis Del Guercio, M.D., professor and chairman of surgery at New York Medical College; Eddie Joe Reddick, M.D., of Nashville, Tenn.; and R. Phillip Burns, M.D., professor and chairman of surgery at the Chattanooga Unit of the University of Tennessee. In addition, this conference will also feature speakers from West Virginia and has been approved for 10 hours of CME.

Special activities at the meeting will include the Annual Residents' Competition, and tennis and golf tournaments.

To register, write to the West Virginia Chapter of the American College of Surgeons, P.O. Box 1107, Morgantown, WV 26505. Room reservations for The Greenbrier can be made by phoning 536-1110.

State ophthalmologists plan annual meeting

The West Virginia Academy of Ophthalmology will conduct its 46th Annual National Spring Meeting at The Greenbrier from April 22-25.

Registration will begin on Thursday, April 22 at 1 p.m. and run until 7 p.m., when a welcome reception is planned. Registration will then be held during the remaining days of the conference from 7:45 a.m. - noon, and the scientific sessions will be presented each day from 8 a.m. - 1 p.m.

This CME program has been designated for 12 credit hours in Category I of the AMA's Physician's Recognition Award and featured speakers will be Peter R. Kastl, M.D., Ph.D., on the subject of contact lenses; Richard L. Lindstrom, M.D., on cataract and corneal surgeries; David H. Orth, M.D., on retinal surgery; and M. Bruce Shields, M.D., on the topic of glaucoma. This year, in addition to the lectures, exhibits and tournaments, a white water rafting trip is being offered for participants.

For more details, contact Pam Stevens at 344-8466.

AMERICAN LUNG ASSOCIATION®
of West Virginia

1993
Golf Privilege Card®

Greens fees worth more than $900 at some of West Virginia's finest courses. It's a great bargain and you'll be helping fight lung disease in our state.

Only $40!

1-800-750-LUNG

Space contributed by the publisher as a public service.

The West Virginia State Medical Association's

1993 Annual Meeting

August 18-21, 1993

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up Now!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

For more details about other area hotels/motels, contact the WVSMA at 304-925-0342. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1993 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code _____

Phone _____

Cost: WVSMA member $125

Non-member $175

Specialty _____

Payment by: Check Visa MasterCard

Card Number _____

Expiration Date _____

Signature _____

If paying by check, please send registration form and check to:

West Virginia State Medical Association

P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

The programs this month were compiled by: Nancie Divvens, associate executive director for the West Virginia State Medical Association; Robin Rector, coordinator for CME for Charleston Area Medical Center; Kari Long, program director of CME and rural services for WVU; David Bailey, director of CME for Marshall University; and Thelma Wilson, education coordinator for Raleigh County Medical Society.

More details about these CME activities may be obtained by calling Divvens at 925-0342; Rector at 348-9580; Long at 293-3937; Bailey at 696-7018; and Wilson at 255-6341.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

Mar. 6 - Third Generation Loss Control Seminar: Marbury vs. Madison, Wheeling

CAMC/WVU Health Sciences Center - Charleston

Mar. 13 - "Spinal Cord Injuries," 8 a.m., WVU Health Sciences Center Auditorium

WVU Health Sciences Center - Morgantown

Feb. 26-27 - "Child, Spouse and Elder Abuse: Breaking the Cycle of Family Violence," WVU Health Sciences Center

Marshall University - Huntington

Mar. 9 - 6th Research Day, Holiday Inn-Gateway Convention Center, Barboursville

Raleigh County Medical Society - Beckley

Feb. 23 - "Rationale for Treatment of Hypercholesterolemia Based on Clinical Trials," Donald W. Romhilt, M.D., 6:30 p.m., Black Knight Country Club

Mar. 4 - "Cardiovascular Risk Factors: Antihypertensive Therapy," Myron Weinberger, M.D., 6:30 p.m., Black Knight Country Club

Mar. 11 - "Update on Allergies and Asthma," L. Blair Thrush, M.D., 6:30 p.m., Black Knight Country Club

Mar. 16 - "Multifactorial Approach to CHD," Julian Espiritu, M.D., 6:30 p.m., Black Knight Country Club

Mar. 23 - "Anxiety and Depression in the Aged and the Medically Ill," Norman Sussman, M.D., 6:30 p.m., Black Knight Country Club

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Gassaway ☐ Braxton County Memorial Hospital, March 10, 7 p.m., "Renal Cell Carcinoma," Bashir Sankari, M.D.

Logan ☐ Logan General Hospital, March 19, 11:45 a.m., "Genes Responsible for Cancer," Arvind Kamthan, M.D.

Madison ☐ Boone Memorial Hospital, March 9, 6:30 p.m., "Thrombolytic Therapy," Judy Chamberlain, R.N., M.S., C.C.R.N.

Man ☐ Man Appalachian Regional Hospital, March 15, 7 p.m., "Trauma," Bruce Hoak, M.D.

Montgomery ★ Montgomery General Hospital, March 3, 12:15 p.m., "Domestic Violence," Lee Neilan, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Feb. 24, 7 a.m., "Hepatitis From A through E," John Thomas, Ph.D.

★ Camden-Clark Memorial Hospital, March 10, 7 a.m., "Anxiety Disorders," P. Van Nickell, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, Feb. 25, noon, "Multi-drug Resistance in Cancer Treatment," Arvind Kamthan, M.D.

☐ Pleasant Valley Hospital, March 25, noon, "Medical Management of Low Back Pain," Janet Cochran, M.D.

Ripley ☐ Jackson General Hospital, March 12, 12:15 p.m., TBA

Spencer ☐ Roane General Hospital, March 16, 12:30 p.m., "Skin Cancer," Brad Cohen, M.D.

White Sulphur Springs ★ Greenbrier Clinic, Feb. 22, 4 p.m., "New Concepts in the Management of BPH," Stanley Kandzari, M.D.

Williamson ☐ Williamson Appalachian Regional Hospital, Feb. 25, 5:30 p.m., "Health Promotion and Disease in the Elderly," Mark Newbrough, M.D.

Electromyography and Nerve Conduction Studies.

★

Prasadarao B. Mukkamala, MD
Diplomate of American Board of Physical Medicine and Rehabilitation.

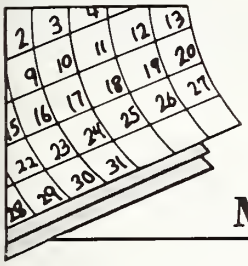
Diplomate of The American Board of Electro-Diagnostic Medicine

★

FOR APPOINTMENT
CALL (304) 344-5153

★

Prasadarao B. Mukkamala, MD
Union Square
1 Monongalia Street
Charleston, WV 25302



Medical Meetings

February

25-26—11th Annual International Symposium on Man and His Environment in Health and Disease, American Environmental Health Foundation, Inc. (sponsor), Dallas

26-March 3—California Medical Association's 122nd Annual Session and Western Scientific Assembly, Anaheim, Calif.

26-27—Starting to Practice Smart, AMA (sponsor), New York

March

1-4—Alton D. Brashear Postgraduate Course in Head and Neck Anatomy, Medical College of Virginia (sponsor), Richmond

5-6—36th Annual Ophthalmology Symposium: Ophthalmic Plastic Surgery for the 1990s, Ohio State University (sponsor), Columbus

5-6—4th Annual Ophthalmology Alumni Weekend, WVU Dept. of Ophthalmology (sponsor), Morgantown

7—Stem Cell and Marrow Processing for Transplantation: Review and Update, American Association of Blood Banks (sponsor), Tampa, Fla.

11-13—Children's Defense Fund's Annual National Conference, Washington, D.C.

11-14—American Medical Directors Association's 16th Annual Meeting, Phoenix, Ariz.

12-14—The Heart of Healing: A Conference on Transpersonal Psychology, Menninger Clinic (sponsor), Topeka, Kan.

13—Depression: Medical Perspectives on Diagnosis and Management, Ohio State University (sponsor), Dublin, Ohio

14-18—American College of Cardiology, Anaheim, Calif.

19—The Ecology of Graduate Medical Education: Part II - Strategies for Change, American Board of Medical Specialties (sponsor), Chicago

20-21—Advanced Trauma Life Support Student™ Course, Georgetown University Medical Center (sponsor), Washington, D.C.

20-21—Immunohematology Reference Laboratory Conference, American Association of Blood Banks (sponsor), Peachtree City, Ga.

21-26—Cardiovascular Disease-The High-Risk Patient: An Interspecialty Approach, Ohio State University (sponsor), Snowmass-Aspen, Colo.

25-26—Laboratory Workshop in Breast Reconstruction, Eastern Virginia Medical School (sponsor), Norfolk, Va.

26-28—West Virginia Urological Society's Annual Meeting, Huntington

For More Information . . .

Contact the Journal at (304) 925-0342 for additional information about most of the above meetings.

Poetry Corner

eliza madi - three

My beautiful daughter
with eyes the color of the sea
who gives me tidbits
so generous to me
how I hope to follow you
for a spell
to find anew the joy of discovery
and share which we see

John Henry McWhorter, M.D., M.P.H

Mature Love

He looks again in wonderment
As if at a mirage
A line there
A greying hair
But still the younger bride peeks through
The ready smile
The tossing head
The regal walk
And in the dead of night
— only the bride.

Martin D. Reiter, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, Box 4106, Charleston, WV 25364.

"THE DOCTOR SAID I'M ALLERGIC TO SPINACH, BROCCOLI AND BEETS AND I NEVER HAVE TO EAT THEM AGAIN."

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

ONS implements Pregnancy Nutrition Surveillance Survey

The Office of Nutrition Services has recently initiated the Pregnancy Nutrition Surveillance Survey (PNSS) through a grant from the Centers for Disease Control.

PNSS was established to assist states in monitoring their progress toward achieving the Healthy People 2000 objectives for low birthweight and infant mortality. While West Virginia currently collects a variety of data related to pregnancy and childbirth, this information resides in numerous, often non-linked data systems. PNSS is intended to access and link these data systems to provide for the clearest possible picture of available statistics. PNSS will also assist agencies in determining trends, planning programming and evaluating program efforts related to improving pregnancy outcomes.

Specifically, WV-PNSS will address access and adequacy of prenatal care, content of prenatal care, patterns of prenatal care, barriers to offering or receiving prenatal care, and early entry into the WIC Program. The initial grant covers a 12-month period with continuation awards available for the duration of a four-year project period.

For more details, contact ONS at 558-0030.

OEHP to release new Behavioral Risk Factor Surveillance Survey

The Office of Epidemiology and Health Promotion (OEHP) will soon release its latest Behavioral Risk Factor Surveillance Survey (BRFS).

This report is a random-sample telephone survey of adult residents used to determine the prevalence of selected health risk factors. Conducted on a yearly basis in conjunction with the Centers for Disease Control in Atlanta, the 1991 BRFS report contains information on non-use of seatbelts, hypertension, obesity, sedentary lifestyle, cigarette smoking, smokeless tobacco use, and alcohol misuse.

For the first time, in the 1991 report data was collected on frequency of routine medical examinations, cholesterol awareness and levels, flu vaccinations, and breast and cervical screenings.

For more details on the BRFS or for a copy of the report, contact Fred King at OEHP at 558-9100.

CDC revises HIV classification system, AIDS definition

The Centers for Disease Control and Prevention (CDC) has revised the HIV classification system and expanded the AIDS surveillance case definition for adults and adolescents ages 13 years or older.

The expanded case definition includes all HIV-infected persons who have less than 200 CD4+ T-lymphocytes/µL, or a CD4+ T-lymphocyte percent of total lymphocytes less than 14. In addition to retaining the 23 clinical conditions in the previous AIDS surveillance definition, the expanded definition includes pulmonary tuberculosis (TB), recurrent pneumonia and invasive cervical cancer.

This expanded definition requires laboratory confirmation of HIV infection in persons with a CD4+ T-lymphocyte count less than 200 cells/µL or with one of the added clinical conditions. The new case definition went into effect on January 1.

AIDS surveillance is the primary means to track the HIV epidemic. In addition, Title I and II funds under the Ryan White CARE Act are distributed through a formula grant based on reported AIDS cases. Physician participation in AIDS case reporting continues to be important to assure the proper assessment of the epidemic and the allocation of funds needed to provide critical services to HIV-infected persons in West Virginia.

One of the area AIDS Surveillance Field Investigators will be contacting physicians in the near future to schedule a meeting to discuss the best way to implement the expanded surveillance definition. Questions should be directed to Loretta Haddy, director of the West Virginia Aids Program, at 1-800-423-1271 or 558-5358.

Accident clarifies effectiveness of medical waste rule

On December 22, a medical waste hauler who was transporting infectious waste to a treatment facility in Kentucky on I-64, lost nine boxes of infectious waste from his trailer when a broken latch allowed a door to open. The accident occurred on the Nitro-St. Albans bridge at approximately 3 a.m. and by checking the manifests employed in the tracking of infectious waste, a rapid determination was made of the number and origin of the lost containers.

Two of the boxes have been retrieved, but the remaining seven have yet to be recovered and are feared in the river. The hauler has established a response team to deal with any discovered waste. The ensuing investigation revealed that the hauler was in substantial compliance with the Infectious Medical Waste Rule (64 CSR 56), but several generators are still in violation of the rule. Many are failing to include the required information on the outside of their infectious medical waste packaging.

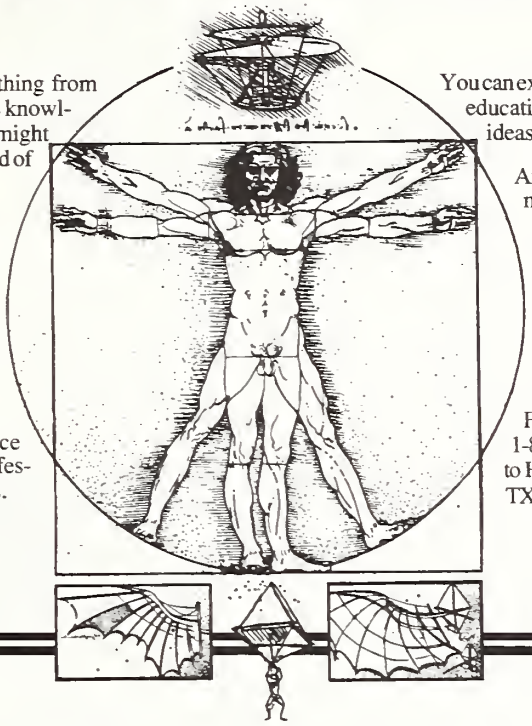
The conditions which contributed to this accident and recommendations for preventing a similar occurrence will be communicated to all medical waste haulers permitted in West Virginia. Those individuals that experience any problems with medical waste management are encouraged to contact the Infectious Medical Waste Program hotline at 1-800-922-1255.

Explore the opportunities.

Leonardo da Vinci did — everything from flight to anatomy — expanding his knowledge and potential. Think what he might have accomplished in today's world of high technology.

If you're a Family Practitioner, Physician Assistant, or Physical Therapist, explore the high-tech world of Air Force medicine — a world where professionals work hand-in-hand giving patients the best care possible without concern for the patient's ability to pay.

You'll enter a ready-made practice with none of the start-up and professional liability insurance expenses.



You can explore opportunities for advanced education to keep you abreast of new ideas in your field.

And chances are good you'll have more time to spend with family and friends, or to pursue a hobby. Plus, there are opportunities for you to explore other countries and cultures. You'll also have the prestige of being an Air Force officer and the pride of serving your country.

For more information, call 1-800-423-USAF. Or send your CV to HQ USAFRS/RSH, Randolph AFB TX 78150-5421.

AIM HIGH

AIR FORCE

West Virginia Chapter

American College of Surgeons

Annual Spring Meeting **April 29 - May 1, 1993**

The Greenbrier - White Sulphur Springs, West Virginia - 10 Hours CME

Guest Speakers:

Louis Del Guercio, M.D.
Professor and Chairman, Surgery
New York Medical College

Eddie Joe Reddick, M.D.
Nashville, Tenn.

R. Phillip Burns, M.D.
Professor and Chairman, Surgery
Chattanooga Unit-University of Tenn.

Other Statewide Speakers, Including the Annual Residents' Competition-Saturday, Tennis Tournament-Thursday, Golf Tournament-Friday.

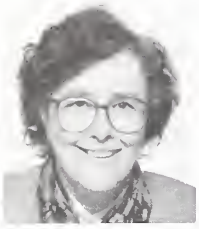
Registration: WV Chapter American College of Surgeons
P.O. Box 1107
Morgantown, WV 26505

Rooms: (304) 536-1110

WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center, Communications Division, Morgantown.

Biochemistry chair is Fulbright Scholar



Beattie

Diana Beattie, Ph.D., chair of biochemistry, will travel to Kenya this month as a Fulbright Scholar.

Dr. Beattie will spend six months at the University of Nairobi conducting research on trypanosomas, a type of parasitic protozoa which is the causative agent for sleeping sickness. Her research at WVU has involved energy metabolism in cells and she will utilize similar techniques in the Nairobi research.

Alzheimer's training program to reach 27 rural counties

The WVU Department of Behavioral Medicine and Psychiatry and the WVU Gerontology Center have received a three-year, $314,000 grant from the National Institute on Aging to develop a model Alzheimer's training project for rural West Virginia.

Training will begin at WVU with professionals in Morgan, Tucker and Ritchie counties. These professionals will then hold sessions with their own staff, who in turn will train professionals in two adjoining counties. This will continue until professionals in all of the 27 designated counties have received instruction.

Counties were selected for participation in the project based on their rural characteristics and representation of residents ages 65 and older.

The project's investigators include Eric Rankin, Ph.D., and Dr. Robert Keefover of the Department of Behavioral Medicine and Psychiatry; and Rick Briggs, M.A., of the WVU Gerontology Center.

WVU selected as site for arrhythmia study

The WVU Health Sciences Center has been chosen as a site for the MUSTT (Multicenter Unsustained Tachycardia Trial) study. The study, sponsored by the National Institutes of Health, is designed to help determine if patients with non-sustained ventricular tachycardia benefit from carefully selected antiarrhythmic therapy.

The study will focus on high risk patients having the arrhythmia in the setting of coronary disease and poor left ventricular function, defined as an ejection of .40 or less. Such patients are at significant risk for sudden cardiac death, but it is not known whether arrhythmia suppression improves their prognosis.

For more information on the study, contact Dr. Stanley Schmidt in the Section of Cardiology, Department of Medicine, at (304) 293-4096.

New division provides dental care to medically compromised

The WVU School of Dentistry, in conjunction with the WVU School of Medicine, has formed the Division of Special Care Dentistry.

The new division, which is part of the Department of Hospital Dentistry, provides a full range of preventive and restorative dental services to the medically compromised, including those undergoing prosthetic replacement, organ transplants, and orofacial reconstruction. The division also cares for oncology patients undergoing head and neck surgery, head and neck radiation therapy, chemotherapy or bone marrow transplantation.

The Division of Special Care Dentistry does not replace Trauma Watch or other ongoing programs established for acute care, nor does it replace established oral surgery programs.

Otolaryngology residents participate in national meeting

Several otolaryngology residents presented posters and gave presentations at the XXIII Pan American Congress of Otorhinolaryngology, November 3-8 in Orlando, Fla. The participating residents were as follows:

- Dr. Rohit Bawa, a third-year resident, gave the presentation "Middle Turbinate Syndrome" with Dr. Hassan Ramadan, assistant professor, as the senior author. Dr. Bawa's posters were "Shy-Drager Syndrome," with Dr. Ramadan as co-author, and "Anaplastic Thyroid Carcinoma," with Dr. Mark Wax, assistant professor, as co-author.
- Dr. John Pickens, chief resident, made a poster presentation on "The Effects of Perioperative Pentoxifylline on Random Skin Flap Survival," with Dr. Stephen Wetmore, professor and chair, and Susan Rodman, data system specialist, as co-authors. Dr. Pickens also gave a lecture on "Laryngeal Tuberculosis in Children," with Drs. Ramadan and Wax as co-authors.
- Dr. Neal Obermyer, a third-year resident, presented a case study on "Adenocarcinoma of the Larynx," with Dr. Ramadan as co-author.

Neurologists treating patients with BOTOX

The faculty in the Department of Neurology are now treating a variety of disorders with botulinum toxin (BOTOX), a drug that decreases the amount of involuntary muscle contraction by temporarily blocking some of the motor nerve endings that supply the muscle.

BOTOX is being used to treat hemifacial spasm, blepharospasm, torticollis, spastic dysphonia, writer's cramp, and limb dystonia. The therapy involves injecting small amounts of BOTOX into overactive muscles.

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH

EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD

Specializing in
Head and Neck Cancer Surgery
Cosmetic Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

- **35-bed JCAHO Accredited Hospital**
- **Ambulatory Care/ Same Day Surgery**

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)

Your CPA: A Business Investment

Your company's not quite doing as well as you think it should, but you're not sure what to do about it. Certified Public Accountants have the education and experience to strengthen internal controls, provide management advice, understand business law, reduce your tax burden and help you with budgetary and financial planning.

Whether your CPA is a company employee or an outside consultant, this professional brings many unique qualifications to your business. Members of The WV Society of CPAs bring integrity, independence, ethical standards and continuing education to their work, backed by the resources of a 1,700-member professional association.

When you want to make a sound investment in your business, use a CPA.

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

Marshall to build Institute of Rural Health Research

Marshall University will expand its national role in rural health research through a new facility which will be called the Marshall Institute of Rural Health Research, President J. Wade Gilley has announced.

The institute will include faculty and staff from the School of Medicine and other Marshall divisions, rural health providers who are affiliated with Marshall, and other authorities on rural medical problems and health-care delivery.

"The institute is being built on the strong foundation of our 10-year-old Section on Rural Health Research, which is one of just a handful in the entire nation," Gilley said.

Gilley has asked Dr. Robert B. Walker to serve as director of the institute. Dr. Walker will continue in his roles as chairman of the Department of Family and Community Health and associate dean for clinical affairs for the School of Medicine.

"Dr. Walker is one of the most respected figures in rural medicine today," Gilley said. "He has provided counsel to his colleagues, two governors, and even Congress. He has been instrumental in getting major grants to fund rural health research, including the first rural cancer prevention project from the American Cancer Society."

The institute will be part of Marshall's Southern West Virginia Center for Rural Health, according to Dr. Charles H. McKown Jr., vice president for health sciences and dean of the School of Medicine. The $4.5 million facility will be paid for as part of the 1993 federal budget and is designed to be a center for rural-oriented medical treatment, teaching, research and support services.

According to Dr. Walker, the institute will conduct rural health research as well as assist others who need help to develop their own projects.

"We have had an extremely active rural research program, especially in the areas of early diagnosis and prevention of cancer in rural people, improved ways of caring for elderly people in rural areas, and the effectiveness of programs that tailor medical education to the needs of rural areas," Dr. Walker said. "We also think that this institute will, perhaps for the first time, make it feasible for rural providers to do their own research. We can offer them support services that provide a certain leavening to their efforts, such as helping them design research proposals, write grants, gather data, develop computer programs, and analyze their results. These are highly specialized services that few rural providers have available."

In addition, the institute will provide access to Marshall's growing rural health library and its learning resource center, computer network, and rural medical education network.

Nerhood named chair of obstetrics/gynecology

Robert Nerhood, M.D., has returned to Huntington to become chairman of the Department of Obstetrics and Gynecology, Dean Charles H. McKown Jr., M.D., has announced.

"Dr. Nerhood brings to Marshall a strong background in both academic medicine and private practice," Dr. McKown said. "He has been a valued member of our volunteer faculty since 1979, and we are delighted that he has agreed to lead our program."

Dr. Nerhood's first priority has been to re-establish Marshall's postgraduate training in obstetrics and gynecology. "Marshall has nearly all the ingredients necessary to put together a residency program," Dr. McKown said. "We're blessed with a core faculty which includes an outstanding oncologist and a recently trained, excellent perinatologist, who are critical components for a training program. Along with two additional full-time faculty obstetricians and gynecologists, we also have in our community Ob/Gyn physicians who have been and continue to be actively involved in our educational programs and very supportive of them."

According to Dr. Nerhood, the program will place particular emphasis on ways doctors specializing in obstetrics and gynecology can function in rural and semirural settings.

Most recently, Dr. Nerhood was an associate professor on the faculty of the University of Massachusetts School of Medicine, where he was chairman of obstetrics and gynecology for the Berkshire Medical Center. From 1987 to 1989, he was director of resident education in obstetrics and gynecology at Allegheny General Hospital/Medical College of Pennsylvania.

Prior to these positions, Dr. Nerhood was a member of OB-GYN Associates Inc. of Huntington from 1975 to 1989 and was involved in medical affairs and health policy at local and state levels. During this time, he directed the West Virginia Improved Pregnancy Outcome Project for Region II, was a member of the West Virginia Perinatal Committee, and served as a board member of the West Virginia Perinatal Association.

Renowned virologist Research Day speaker

Dr. Erling Norrby, an internationally renowned virologist who served on the Nobel Prize Committee, will be the keynote speaker for Marshall's Sixth Annual Research Day.

Dr. Norrby will present the Research Day Opening Lecture, "Immunization Against HIV-2 and SIV in Cynomolgus Macaque Monkeys," at 7 p.m. on March 8 in Marshall's new Fine Arts Building at 1659 Fifth Ave. The lecture is free and open to the public.

All other Research Day events will take place on March 9 at the Holiday Inn-Gateway Convention Center in Barboursville. Students, residents and faculty members will present research and case studies throughout the day. Dr. Norrby will discuss the Nobel Prize selection process at the luncheon.

For registration and CME credit, call 696-7019.

THE WHEELING CLINIC

WHEELING, WEST VIRGINIA 26003

Wheeling, 234-2000 • St. Clairsville, (614) 695-2511 • New Martinsville area, 455-2222 • Wellsburg-Steubenville area, 737-3700
Martins Ferry area, (614) 633-1517 • toll-free no. out of state, 1-800-245-8015

INTERNAL MEDICINE

General
D. J. Panucci, M.D.
P. R. Hedges, M. D.
R. N. Lewis, M. D. (St. Clairsville)

Peripheral Vascular Disease
J. D. Holloway, M. D.

Cardiovascular
A. M. Valentine, M. D.
W. E. Noble, M. D.

Rheumatology
R. Vawter, M. D.

GENERAL SURGERY
E. C. Voss, M. D.
G. Galvin, M. D.
E. Cohen, M. D.

UROLOGY
D. C. Trapp, M. D.

OPHTHALMOLOGY
R. V. Pangilinan, M. D.
D. Simbra, M. D.
H. F. Leeper, M. D., Ph.D.
Kathryn M. Clark, O. D.

OTOLARYNGOLOGY/ MAXILLO-FACIAL SURGERY
W. A. Tiu, M. D.
A. G. Matadar, M. D.

RADIOLOGY
Valley Radiologists, Inc.

FAMILY PRACTICE
G. L. Cholak, M. D. (St. Clairsville)
E. L. Coffield, M. D. (New Martinsville)
C. P. Entress, M. D.
J. H. Mahan, M. D. (St. Clairsville)

PODIATRY
B. Blank, D.P.M. (St. Clairsville)

DERMATOLOGY
G. A. Ganzer, M. D.

NEUROLOGY
H. L. Kettler, M. D.

BEHAVIORAL MEDICINE
S. D. Ward, M. D. (Martins Ferry)
D. P. Hill, M. D. (Martins Ferry)
R. Paolini, D. O. (Martins Ferry)

ANCILLARY SERVICES
Optical
Speech Therapy/Audiology
Counseling/Group Therapy
Biofeedback Laboratory
Electrology/Cosmetic Therapy
Electrocardiography
Electroencephalography
Neurological Studies (Non-invasive)
Roentgenology
24° A/EEG Scanning Service
Cardiac Ultrasound
Clinical Laboratory

Wonderful
WEST VIRGINIA

If there's one magazine that should be in YOUR waiting room, it's definitely **Wonderful WEST VIRGINIA**

Wonderful WEST VIRGINIA will entertain your patients with articles on historic places, state parks and forests, recreational opportunities and our beautiful flora and fauna. In addition, the magazine will continue to feature West Virginia's scenic beauty in stunning color photographs.

For a special low price of $10.00 a year -- *60% off the newsstand price*-- you can have your waiting room filled with West Virginia pride!

Just call our office at 558-9152 or 1-800-CALL- WVA to start your subscription today!

Medical Student News

REMEMBER WVSMA-MSS IS YOU!

Dear Fellow Medical Students:

Please allow me to begin by saying how glad I was for the opportunity to meet so many of you at the annual meeting of the WVSMA Medical Student Section in Charleston, and how helpful it was to share your ideas about our future goals and focus. I anticipate an exciting year ahead and am looking forward to the opportunity to meet even more of you.

As I related to the members attending the House of Delegates meeting at the Mid-Winter Clinical Conference, it is my firm belief that the time to become involved in the WVSMA is not as a resident, or as a graduating medical student, but ON THE DAY OF ADMISSION TO MEDICAL SCHOOL. In this time of swiftly changing health care policies and issues, such involvement will provide us with the knowledge and experience to immediately take our place as active participants in the WVSMA the day we begin to sign M.D. behind our signature.

I anticipate a year filled with activity, and I am depending on you, the members of WVSMA-MSS, to help me and the other officers plan activities of value by taking an active role in our organization. The new officers are:

Mark S. Wright, President
Marshall University School of Medicine

David Artz, Vice-President
WVU School of Medicine, Charleston Division

Myra Wilkerson, Secretary-Treasurer
Marshall University School of Medicine

My goal as your president is to see an increase in active participation by all members of the respective chapters, both at the local level and with the Executive Council. I realize how difficult it can be to find time in your busy study schedules to become involved in major projects, but simple participation in local meetings and making your opinions known to your local officers and councilors will have a great impact in keeping communication between chapters open and planning programs that are of interest to the entire membership. In April, the Executive Council will be meeting to discuss goals for this year, so please make your opinions known to your local representatives in order for them to represent your views at this important meeting.

Finally, I would like to thank you for the opportunity to be your representative. During my term as president of the Marshall University component society, I had the great pleasure of seeing our membership swell to 100 active members. It is my hope to see this kind of growth in membership and participation throughout the state in the coming year.

REMEMBER WVSMA-MSS IS YOU! TAKE AN ACTIVE PART!

Mark S. Wright
WVSMA-MSS President

Davis & Davis Accounting Services

602 Tennessee Avenue • Charleston, WV 25302
• 304-343-4656 • 800-281-4572 • FAX 304-343-4657

Davis and Davis Accounting provides efficient electronic medical billing to help you receive faster reimbursement. We can bill insurance companies daily, weekly, monthly and/or on demand. As a result of prompt billing, the turnaround time on your reimbursement claims can be reduced by as much as 30 days.

We provide:

- filing of all primary and secondary insurance claims
- patient billing - as lump sum or budget payments
- collections - open line posting, follow up letter on late payments, problem accounts (three letters and turn over for collection)

Billing System equipped with:

- line error checking
- account aging
- cycle billing capablilities
- open line posting
- custom reports tailored to you individual practice

THE MYERS CLINIC — Philippi, West Virginia

Notice: Seeking Internal Medicine, Pediatrics, and/or Family Practice, must be Board Certified or Board Eligible.

Also: Seeking Locum Tenen—Family Practice

Contact: Lonnie L. Crane, 112 North Woods Street, Philippi, WV 26416. 1-(304) 457-2800

Radiology:
Halberto G. Cruz, M. D.

Surgery:
J. W. Woodford, M. D.

Internal Medicine:
Karl J. Myers, Jr., M. D.
Z. Moussa, M. D.

Pathology:
Fulvio Franyutti, M. D.

Pediatrics:
E. G. Kreider, M. D.

ASSOCIATES IN OBSTETRICS AND GYNECOLOGY

OFFERING PERSONALIZED CARE 24 HOURS A DAY 7 DAYS A WEEK
FOR OBSTETRICAL & GYNECOLOGICAL EMERGENCIES & FOR INFANT DELIVERY

OUTPATIENT & OFFICE SURGERY

9 MEMBER GROUP OF OB-GYN SPECIALISTS

CHARLES W. MERRITT, M.D.
ROBERT P. PULLIAM, M.D.
OWEN C. MEADOWS, M.D.
MICHAEL T. WEBB, M.D.
ANGEL L. ROSAS, M.D.
NANCY R. WEBB, M.D.
NORMAN W. TAYLOR, M.D.
WILLIAM A. SCARING, M.D.
NORMAN L. SIEGEL, M.D.

- CONTRACEPTIVE COUNSELING
- ARTIFICIAL INSEMINATION
- UROLOGICAL EVALUATIONS & TREATMENT
- INFERTILITY EVALUATIONS
- BREAST SCREENING

255-1541

410 CARRIAGE DR. BECKLEY

New Members

We want to welcome the following new members to the WVSMA:

Kishor Pathak, M.D.
300 Grandview Avenue
Princeton, WV 24740

Lorenzo Gonzales-Lavin, M.D.
2828 1st Avenue #100
Huntington, WV 25701

Rodger A. Blake, M.D.
1035 3rd Avenue
Huntington, WV 25712

Warren S. Rogers, M.D.
2008 Kanawha Blvd. E.
Charleston, WV 25301

Edwin E. Cohen, M.D.
58 16th Street
Wheeling, WV 26003

William M. Almasy, M.D.
1000 Locust Avenue
Fairmont, WV 26554

Nazik Youssef, M.D.
901 Jefferson Avenue
Glen Dale, WV 26038

Susan W. Miller, M.D.
140 W. Main Street
Bridgeport, WV 26330

Robert Ball Jr., M.D.
Medical Park
Wheeling, WV 26003

Constance Haydon, D.O.
1400 6th Avenue
Huntington, WV 25701-2421

John A. Willis, M.D.
P.O. Box 11137
Charleston, WV 25304

Timothy Saxe, M.D.
1236 6th Avenue
Huntington, WV 25701

Steven L. Maxwell, D.O.
99 J. D. Anderson Drive
Morgantown, WV 26505-2850

Lawrence Minardi, M.D.
500 Donnally Street
Charleston, WV 25301

D. M. Jayaram, M.D.
1719 Sierra Road
Charleston, WV 25314

Harold E. Harvey II, M.D.
214 Professional Park
Beckley, WV 25801

Timothy A. Conner, M.D.
P.O. Box 11137
Charleston, WV 25339

Suresh Agrawal, M.D.
2520 Valley Drive
Point Pleasant, WV 25550

County Societies

Marion

The society's January meeting was held with the administrators and employees of Fairmont General Hospital.

Speakers for this meeting included representatives of the WVSMA, West Virginia Hospital Association and delegates to the West Virginia Legislature.

For you. For her. For Life. Keep your heart healthy.

American Heart Association

Revenue Optimization

What is Revenue Optimization?
Revenue Optimization addresses the fundamentals which govern your gross revenue and, therefore, your net income.

FEE ANALYSIS
- Your fees are converted to a relative value basis using the Systemetrics-McGraw/Hill relative value system.

CODING/REIMBURSEMENT ANALYSIS
- We analyze and evaluate your procedure code usage (and non-usage), including levels of service for the office, hospital, consultation and ER/Outpatient service as well as your use of modifiers.
- We review your insurance claim forms and your EOBs to find ways to maximize your reimbursements, minimize reductions and denials, and minimize the chance of audit.

MEDICARE/RBRVS
- The primary function is to protect your revenue under both par and non-par status, enabling you to make a rational and objective decision about your participation status with Medicare.
- In the process, we calculate your Medicare allowed amount and the co-payment amount for every procedure under both par and non-par status. RBRVS Analysis is included, showing you the effect of RBRVS on each code you use and on all codes collectively.

ON-SITE CODING/ REIMBURSEMENT
- If your personnel needs hands-on help, we come to you. We "audit" your complete reimbursement system including: procedure coding, diagnosis coding, charges, claims filing, reimbursements, and chart documentation. If needed, we will provide classroom and hands-on training for individuals or your entire staff.

YOUR SATISFACTION IS GUARANTEED
- If we do not help or if you are not satisfied with the results of your analysis — your money will be refunded!

America's Premier Consulting Firm Advising Physicians Throughout Our Nation Since 1956

RCFA Physician Managers Inc.
9724 Kingston Pike, Suite 1200
P.O. Box 23590
Knoxville, TN 37933-1590

Professional Practice Planners
332 Fifth Avenue • Suite 213
McKeesport, Pennsylvania 15132

Call Stan Pollock,
DMD, CFP, PHD, CPBC, CBA
(412) 673-3144 • 1-800-635-4040

Matthew Murrill Ralsten, M.D.

Dr. Matthew Murrill Ralsten, 92, of Beckley, died January 7 in a Beckley hospital, following a short illness.

Dr. Ralsten spent his childhood in his hometown of Union, and after finishing high school he trained as a secretary-bookkeeper at National Business College in Roanoke, Va. During the latter part of World War I, he worked at the Government Munitions Plant in Nitro. He came to Beckley on January 1, 1922, and became a secretary-bookkeeper for Beckley Hospital.

After earning a degree in pre-medicine at West Virginia University, he attended the Medical College of Virginia in Richmond and graduated in 1930 with his medical degree. He completed a three-year general rotating internship in orthopedic surgery and became an orthopedic specialist at Beckley Hospital.

During his career, Dr. Ralsten was also an attending physician at Oak Hill Hospital, Wyoming General Hospital, the Veterans Administration Medical Center and Pinecrest Hospital. In addition, in 1964 he was appointed medical director of both Beckley Hospital and Oak Hill Hospital, serving until his retirement in 1981. Dr. Ralsten had continued to have an active role at Beckley Hospital in an administrative capacity until recent years, serving on the hospital's board of directors.

A member of the WVSMA since 1936, Dr. Ralsten was a past president of the Raleigh County Medical Society, and was also a member of the AMA and the American College of Surgeons. He was a member and past president of the Beckley Rotary Club, a past president of the Raleigh County Historical Society, an elder and member of the Beckley Presbyterian Church, and a Paul Harris Fellow.

An early organizer of the Beckley Child Care Center, Dr. Ralsten had served on the board for many years.

Dr. Ralsten and his wife, Margaret Lucille "Teelie" Campbell Ralsten, were recently honored by the Beckley-Raleigh County YMCA as the 1992 recipients of the Spirit of Beckley Community Service Award. They had been instrumental in the restoration of General Alfred Beckley's former home, now known as Wildwood. The Ralstens were one of the 16 founding families of the Raleigh County Library.

In addition to his wife, Dr. Ralsten was survived by a son, Dr. John Neville Ralsten of Parkersburg; five grandchildren; four nieces; and two nephews. He was preceded in death by a son, Matthew Murrill Ralsten Jr.; and three sisters, Ruth Woodrum, Catherine Waller and Ellen Chrisman.

Gary Maurice Tolley, M.D.

Dr. Gary Maurice Tolley, 57, a Huntington radiologist, died January 30 while vacationing at Snowshoe Ski Resort in Pocahontas County.

Dr. Tolley graduated from Huntington East High School and later received a bachelor of science degree from Marshall University in 1957. He then began medical school at West Virginia University and received his medical degree from the Medical College of Virginia in 1961.

After serving with the U.S. Navy Medical Corps, he completed his graduate medical education at the University of Indiana.

Dr. Tolley had served for four years as chairman of radiology for the Marshall University School of Medicine and had served as chief of radiology at Cabell Huntington Hospital for six years. He was a former president of the Cabell County Medical Society and a former president of the medical staff at Cabell Huntington Hospital.

His close friend and colleague, Dr. Charles H. McKown Jr., M.D., dean of the Marshall University School of Medicine, commented, "For those of us at Marshall, Gary was more than an outstanding practitioner and teacher; he was a strong leader in medical affairs and medical administration during an era of delicate and sometimes awkward transition. To any process, he provided wisdom, vision, and balance. It's a great loss to our entire community."

For over 25 years, Dr. Tolley had been a member of Radiology Inc. in Huntington, practicing diagnostic and therapeutic radiology and nuclear medicine. In addition to being a member of the WVSMA and Cabell County Medical Society, he was also a member of the AMA, American Board of the College of Radiology, American Board of Nuclear Medicine, and John Marshall Society. He was also on the board of directors for John Marshall Medical Services.

Surviving is his mother, Virginia L. Tolley Brandt; stepfather, George "Bud" Brandt, both of Huntington; wife, Wanda G. Chain Tolley; four sons, Stephen Gregory Tolley and fiancée Dr. Christine Wessels, Mark Kevin Tolley and fiancée Marcia Adkins, David Brian Tolley and wife Marla Tolley, and Joseph Andrew Tolley and wife Kristy Tolley; three granddaughters, Melanie Tolley, Heather Tolley and Tiffany Tolley; one grandson, Evan Tolley; and one sister, Cathy Law, of Seymore, Ind.

West Virginia Medical Journal

ADVERTISING RATES

Full Page Color Advertisements:

Four Color, (back cover)	$925
Four Color, (inside back cover)	$825
Four Color, (inside)	$550
Spot Color	add $175

Black & White Advertisements:

Full Page, (inside front cover)	$450
Full Page, (inside back cover)	$450
Full Page, (back cover)	$450
Full Page, (inside)	$300

Ad Size	1x	3x	6x	12x
Color	$550	$525	$500	$475
Full Page B/W	$300	$275	$250	$200
1/2 Page	$175	$150	$125	$100
1/3 Page	$150	$125	$100	$ 80
1/6 Page	$125	$115	$100	$ 80

Sizes

Full Page	7 1/2" x 10"
1/2 Page (Horizontal)	7 1/2" x 4 3/4"
1/2 Page (Vertical)	3 1/2" x 10"
1/3 Page (Horizontal)	7 1/2" x 3 1/4"
1/3 Page (Vertical)	2 1/4" x 10"
1/6 Page (Vertical)	2 1/4" x 4 3/4"

Classified Ads

Each line measures 2 1/2 inches or 15 picas. The cost per line is $5. There is a minimum charge of $25 per ad. A discount of 10% is deducted for a six-time insertion.****

Subscription Rates

Single Copy	$3
United States	$36 per year
Foreign Countries	$60 per year

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA
MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Special Section

Highlights of the WVSMA's 1993 Mid-Winter Clinical Conference 94

Scientific Newsfront

An analysis of 38 cases of low-grade cerebral astrocytoma in adults
Steven J. Jubelirer, M.D.; Mark Rubin, MSIII; and Chull Shim, M.D. 102

Indications for carotid endarterectomy
Howard H. Kaufman, M.D., and Joseph L. Voelker, M.D. 106

New Manuscript Guidelines 108

Nd:Yag laser surgery of venous malformations
Romeo Y. Lim, M.D., F.A.C.S. 109

President's Page

??????????? 112

Editorial

Making Sense 113

In My Opinion

If elective abortion is not wrong, nothing is wrong 114

Special Departments

General News 116
Continuing Medical Education 118
Medical Meetings/Poetry Corner 119
Bureau of Public Health News 120
WVU Health Sciences Center News 122
MU School of Medicine News 124
Auxiliary News 126
New Members/County Societies 128
Obituaries 129
Classified 133
March Advertisers 134

Front Cover

A bright blue sky filled with fluffy white clouds heralds the beginning of spring in Renick in Greenbrier County. Photo courtesy of *Scott Durham* of Pineville, West Virginia.

SPECIAL SECTION

Mid-Winter Clinical Conference

Highlights of the West Virginia State Medical Association's 1993 Mid-Winter Clinical Conference

January 21-24, 1993

Holiday Inn - Charleston House
Charleston, West Virginia

We wish to thank the participants of the WVSMA's 1993 Mid-Winter Clinical Conference and the Scientific Meeting of the West Virginia Chapter of the American College of Physicians.

Your commitment and support strengthens the Association and is vital to its continuing success.

Senator Jay Rockefeller gestures as he delivers his presentation on "Patients, and Their Doctors: What Does the Future Hold?" during the combined Physician and Public Session at this year's WVSMA Mid-Winter Clinical Conference.

Deanna Myers, district Medicare manager for West Virginia, informed WVSMA members about a statewide Medicare fee schedule.

Following his speech, Senator Rockefeller talked with many of the participants at the meeting, including Dr. Kalid Hasan and WVU medical students Kevin Kaufman, David Artz and Heather Mertz. Kevin served as president of the WVSMA's Medical Student Section during the past year, and David was elected vice president of the MSS during the Mid-Winter Clinical Conference.

WVSMA President Dr. Robert Pulliam was interviewed by West Virginia Public Radio reporter Jim Wallace about his views on health care issues in West Virginia.

Dr. Robert D'Alessandri, vice president for health sciences at WVU and dean of the WVU School of Medicine, responds to a question during the roundtable discussion on problems in health care delivery which was held during the Second Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. The other panelists pictured are Dr. Charles Turner, a past president of the WVSMA; Elizabeth Chalmers, senior associate for ACP government relations; and Dr. Derrick Latos, senior councilor-at-large of the WVSMA.

Photo Highlights

Dr. John Vanin, associate professor of psychiatry and family practice at WVU, was one of the speakers for the Second Scientific Session, which highlighted "Controversies in Medicine."

Dr. David Morgan (left) and Dr. Derrick Latos (right) proudly pose with Dr. Robert Marshall, governor of the West Virginia Chapter of the American College of Physicians, after they were named the 1993 recipients of the Laureate Award.

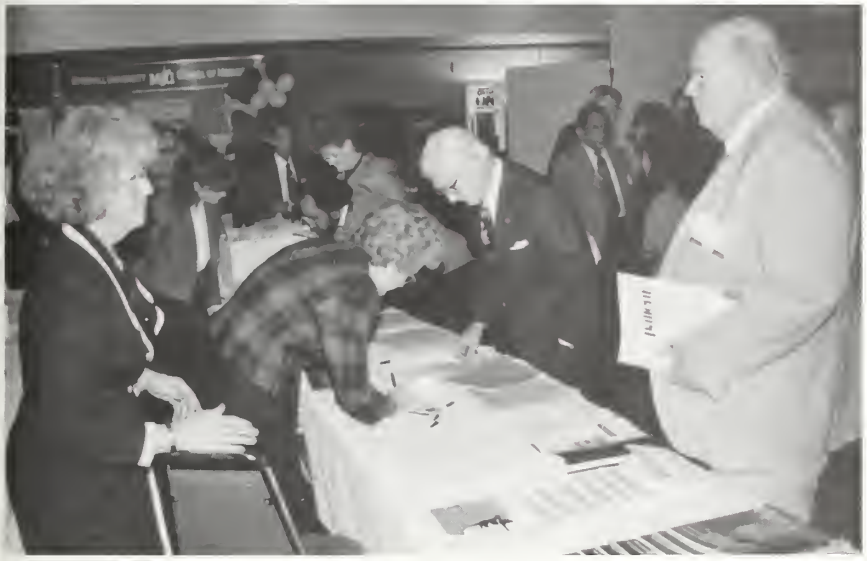
"Advances in Gastrointestinal Endoscopy" was the title of Dr. Peter Cotton's lecture, which he delivered during the First Scientific Session. Dr. Cotton is a professor of medicine and chief of endoscopy at Duke University.

Nancie Divvens, associate executive director of the WVSMA, and Donna Webb, membership coordinator for the WVSMA, helped register participants for the Second Annual Scientific Meeting of the WVACP.

Dr. Jerry Edens talks with representatives from Roche Biomedical Labs while visiting their company's booth in the Exhibit Center.

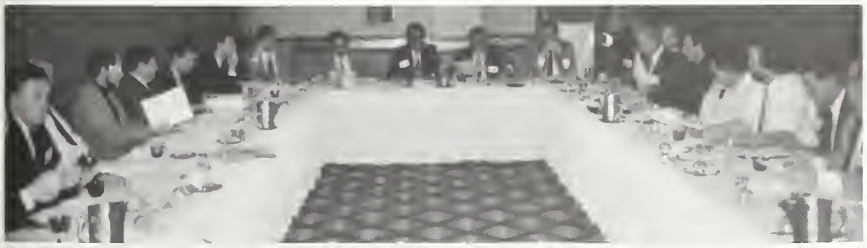
Dr. Daniel Foster, chairman of the Mid-Winter Clinical Conference Committee, directs a question to Dr. Michael Miller, professor of biochemistry at WVU, following Dr. Miller's lecture on "Molecular Biology for Practicing Physicians."

During the special meeting of the WVSMA House of Delegates, WVSMA President Dr. Robert Pulliam discussed the Health Care Planning Commission's Report.



WVSMA staff members Sue Shanklin (front), Shirleen Lipscomb (center) and Michelle Ellison (back) assist participants at the WVSMA's registration desk.

Dr. John Holloway of Wheeling presented an update on the activities of the Healthy West Virginia Coalition.



WVSMA Council members held a breakfast meeting on Sunday, January 24, the last day of the conference.

Photo Highlights

Dr. Rano Bofill entertained guests with his talented singing at the special show which was held on Saturday evening January 23.

WVSMA Auxiliary President Pacita Salon and Dr. Jun Neri combined their beautiful voices for a powerful performance during the Saturday evening show.

Renowned sleep disorders expert Dr. William Dement questioned the audience at the Fourth Scientific Session about many of society's illogical behaviors concerning sleep that have dangerous consequences.

Dr. and Mrs. Samuel Strickland (left), Dr. and Mrs. John Traubert, and WVSMA President-Elect Dr. James Comerci and his daughter Michele enjoyed dancing.

WVSMA Receptionist Teresa Crouch and WVSMA President-Elect James Comerci drew the names of the lucky door prize winners.

The West Virginia State Medical Association's

1993 Annual Meeting

August 18-21, 1993

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up Now!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

For more details about other area hotels/motels, contact the WVSMA at 304-925-0342. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1993 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code _____

Phone _____

Cost: WVSMA member $125

Non-member $175

Specialty _____

Payment by: Check Visa MasterCard

Card Number _____

Expiration Date _____

Signature _____

If paying by check, please send registration form and check to:

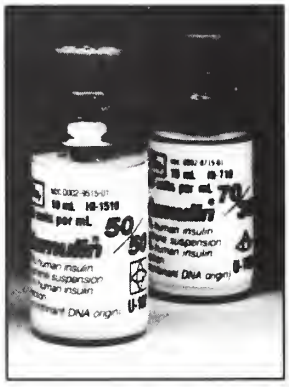
West Virginia State Medical Association

P.O. Box 4106, Charleston, WV 25364

Because One Size Doesn't Fit All...

New Humulin 50/50 is the tailor-made answer to individual patient needs. A unique combination of equal amounts of Regular human insulin and NPH human insulin, it will be useful in situations in which a greater initial insulin response is desirable for greater glycemic control.

Like Humulin 70/30*, new Humulin 50/50 offers the convenience and accuracy of a premix. And it can be used in conjunction with an existing 70/30 regimen.



New Humulin® 50/50

50% human insulin isophane suspension
50% human insulin injection (recombinant DNA origin)

The Newest Option in Insulin Therapy

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

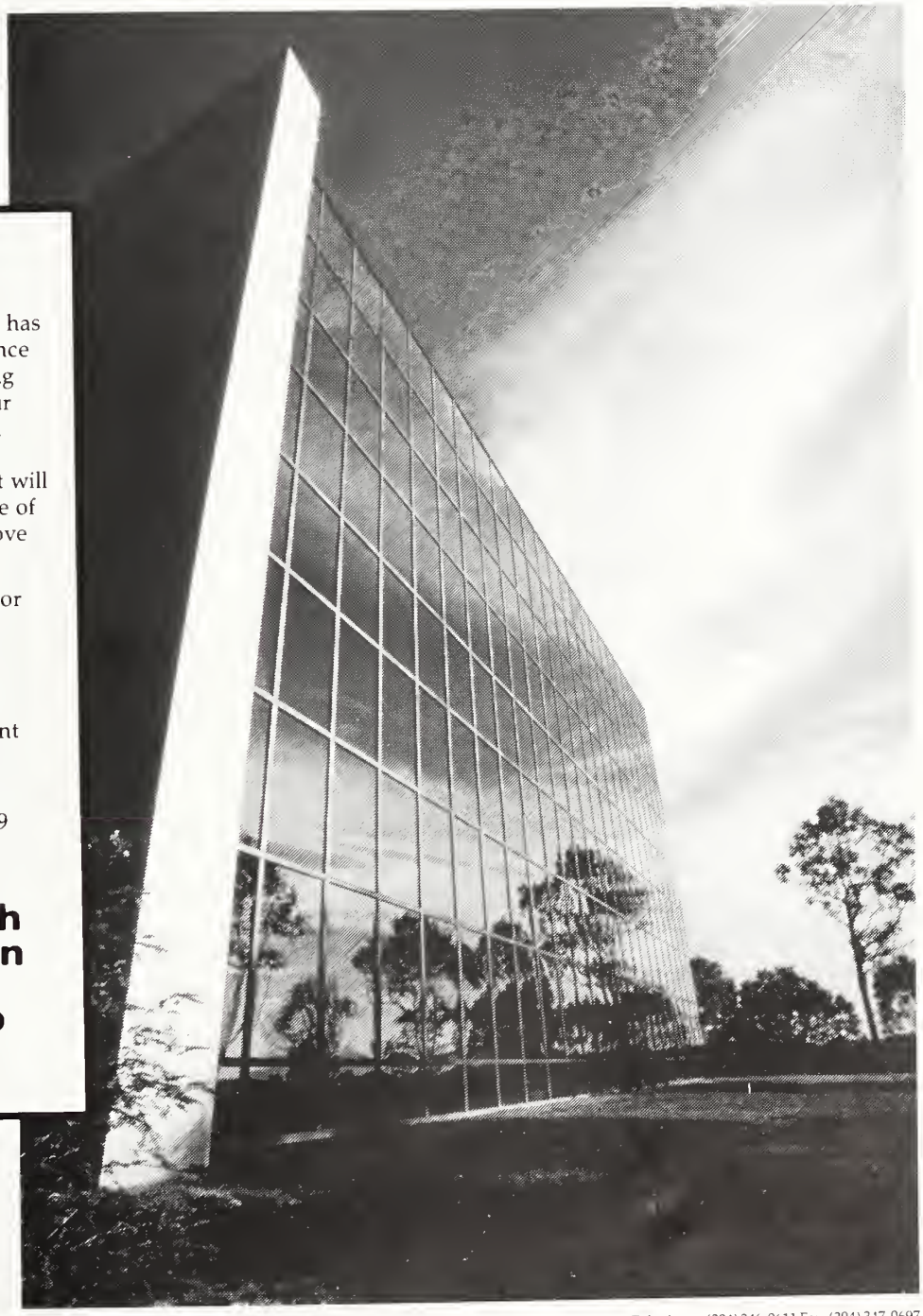
*Humulin® 70/30 (70% human insulin isophane suspension, 30% human insulin injection [recombinant DNA origin]).

Lilly

Global Excellence in Diabetes Care
Eli Lilly and Company
Indianapolis, Indiana
46285

HI-7911-B-249343 © 1992, ELI LILLY AND COMPANY

Service is the cornerstone of our business.



Upon a foundation of experience and professionalism, McDonough Caperton has built a regional insurance brokerage firm assisting clients nationwide. Our mission is to provide a distinctive service of outstanding value that will remain the cornerstone of our business as we move forward.

- Comprehensive Major Medical
- Professional Office Overhead
- Term Life
- Medicare Supplement
- Disability Income
- Hospital Indemnity

Call Us. 1-800-344-5139
Extension 708

McDonough Caperton Insurance Group

Corporate Headquarters One Hillcrest Drive, East, P.O. Box 1551, Charleston, WV 25326-1551, Telephone: (304) 346-0611 Fax: (304) 347-0697
With Offices Located in: Florida, Georgia, Kentucky, Ohio, Pennsylvania, Virginia, West Virginia and Bermuda

An analysis of 38 cases of low-grade cerebral astrocytoma in adults

STEVEN J. JUBELIRER, M.D.
Director, Cancer Care Center of Southern West Virginia, Charleston Area Medical Center; and Clinical Professor of Medicine, West Virginia University - Charleston Division, Charleston

MARK RUBIN, MSIII
Marshall University School of Medicine, Huntington

CHULL SHIM, M.D.
Associate Clinical Professor of Pathology, West Virginia University - Charleston Division, Charleston

Abstract

We retrospectively reviewed 38 cases of low-grade non-pilocytic astrocytoma diagnosed at the Charleston Area Medical Center between 1957 and 1987. All patients underwent craniotomy (total resection in 8 and subtotal in 24) or sterotactic needle biopsy (6 patients). Twenty-eight patients (74%) received radiotherapy, 25 of whom received ≥ 5,000 cGy. The median survival of all patients was 46 months and nine patients (24%) survived ≥ 5 years. Patients under age 40 had a longer survival than those age 40 or older (59 months vs. 30.5 months, p < .05). There was no significant difference in mean survival between those who received and those who did not receive radiotherapy after incomplete surgical resection (49 months vs. 53 months, p = 1.00). Of the 29 deaths, 15 were due to malignant transformation to a high-grade glioma and 12 to recurrent low-grade glioma. Since the role of radiotherapy is unclear, it is important that patients with low-grade glioma participate in clinical trials

Introduction

Low-grade gliomas constitute about 10% of primary brain tumors (1,2). Their optimal treatment and its timing remain controversial. Whether surgical intervention should be performed at the time of diagnosis or at progressive neurologic deterioration, and whether the addition of radiotherapy is beneficial, is still not completely elucidated.

This study retrospectively analyzes the Charleston Area Medical Center (CAMC) experience for 38 adults with histologically proven low-grade cerebral non-pilocytic astrocytoma over a 30-year period in an attempt to clarify the natural history and definitive management of these lesions.

Materials and methods

The records of patients treated at CAMC between 1957 and 1987 for low-grade astrocytoma of the cerebral hemispheres were examined. In order to be included in this study, each patient had to have a histologically confirmed low-grade astrocytoma without evidence of anaplasia, nuclear pleomorphism, coagulation necrosis and with minimal or no mitoses. The hospital records, tumor registry records, pathology reports, operative notes, and radiotherapy reports were reviewed.

The information obtained for each patient included sex, age at diagnosis, symptoms at presentation, duration of symptoms, diagnostic procedures, type of surgery performed, location of the tumor, pathologic diagnosis, radiation dosage, survival period, and cause of death.

Prior to 1981, the diagnosis and location of these astrocytomas were determined by cerebral angiography (13 cases), pneumoencephalogram (2 cases), and electroencephalography (13 cases). Since 1981, all cases have been diagnosed by CT scan (25 cases) and/or magnetic resonance imaging (3 cases). The parietal and frontal lobes were the most commonly involved. Only one patient presented with an occipital-lobe lesion.

Only patients with astrocytoma were included in this study, and these cases were graded using the Kernohan Classification with grades I and II being "low grade." Ten patients were diagnosed as grade I astrocytoma and 28 as grade II.

Table 1. Clinical summary in 38 patients with low-grade astrocytoma

Parameter	Cases	
Age (years)	Number	%
≤ 40	21	55
> 40	17	45
Sex (M:F)	20:18	53:47
Symptoms at Presentation (may be multiple)		
seizures	23	61
headache	21	56
visual field defects	11	29
cerebral sensory	9	24
cerebral motor	8	21
memory loss	7	18
dizziness	7	18
hemiparesis	7	18
personality change	4	11
nausea/vomiting	4	11
unknown	5	14
Duration of Symptoms		
< 1 month	13	34
1-3 months	12	31
3-6 months	4	11
6-12 months	2	5
> 12 months	3	8
unknown	4	11
Tumor Location (may be multiple)		
parietal	18	47
frontal	17	45
temporal	13	34
occipital	1	3
Histology		
grade I	10	
grade II	28	
Extent of Surgery		
Total	8	21
Subtotal	24	63
Biopsy	6	16
Radiotherapy		
< 4000 cGy	2	5
4000 - 4999 cGy	1	3
5000 - 5999 cGy	16	42
≥ 6000 cGy	9	24
None	10	26
Survival (months)		
< 6	4	11
6-12	3	7
12-24	4	11
24-48	9	24
> 48	18	47
Causes of Death		
High Grade Astrocytoma	15	51
Recurrent Low Grade Astrocytoma	10	31
Oligodendroglioma	2	6
Pneumonia	1	4
Primary Biliary Cirrhosis	1	4
Unknown	1	4

Table 2. Clinical information on long-term (≥ 5 years) survivors with low-grade non-pilocytic astrocytoma

Age at Diagnosis	*Sex*	*Treatment*	*Date of Diagnosis*	*Survival as of 7/92 (Months)*	*Clinic Status*
24	M	Surgery and Radiotherapy 6,000 cGy	11/12/85	79	NED*
29	F	Surgery (Total Resection)	1/3/85	90	NED
30	F	Surgery (i.e. Craniotomy)	8/5/74	214	NED
29	F	Craniotomy (Left Frontal) & Radiotherapy (6,000 cGy)	8/10/84	95	NED
26	F	Craniotomy (Cerebellum) + Radiotherapy 4,500 cGy	8/31/92	119	NED
37	M	Craniotomy (Posterior Temporal) + Radiotherapy (6,000 cGy)	4/4/85	87	Has Recurrent Grade II Astrocytoma and is totally disabled
24	F	Craniotomy (Left Posterior Temporal) + Radiotherapy (5,000 cGy)	8/19/85	83	Patient has seizures controlled with Dilantin, but MRI reveals NED
41	M	(Right Frontal)	5/19/66	314	NED
17	F	Craniotomy (Right Frontal) + Radiotherapy 6,000 cGy	6/5/77		Patient died with recurrent low-grade astrocytoma on 7/11/92

Tumors were upgraded to grade III or anaplastic astrocytoma if they exhibited areas of markedly increased cellularity or significant pleomorphism. Readily identifiable mitoses and hyperchromasia were frequent accompanying features. The diagnosis of glioblastoma multiforme (astrocytoma grade IV) was made when one or more foci of coagulation necrosis involving astrocytic tumor cells were identified histologically.

All patients underwent either craniotomy (total resection in eight and subtotal in 24) or needle biopsy (6 patients). Twenty-eight patients (74%) received cobalt radiotherapy, 25 of whom received a total dose of at least 5,000 cGy given in 180 cGy daily fractions.

Survival data was recorded as the length of time from diagnosis to death or latest follow-up evaluation. Operative deaths were defined as deaths within 30 days or during the same hospitalization. Deaths were otherwise noted to be as a result of the tumor or from other causes. Differences in mean survival were tested using the Wilcoxon Statistic.

Results

Twenty (53%) of the 38 patients were males. The median age at diagnosis was 40 years (range: 24-67 years). Four patients were older than 56 years and 11 were younger than 34.

The presenting symptoms are outlined in Table 1. Seizures, headache, and visual field defects were the most common presenting symptoms. Eighty-percent of patients had multiple symptoms (i.e. greater than one) at presentation. Two patients were asymptomatic at presentation. The duration of symptoms was less than one month in 13 patients (34%); 1-3 months in 12 (31%); 3-6 months in four (11%); 6-12 months in two (5%); greater than 12 months in three (8%); and unknown in four (11%).

The median survival for all patients was 46 months (range: 0-314 months). Nine patients (24%) survived at least five years, eight of whom were still alive as of July 1992 (Table 2). One patient had recurrent disease 87 months after the initial diagnosis and is totally disabled. The remaining seven patients are free of disease and quite functional. Six of these patients have full-time employment. None have had CT/MRI evidence of or biopsy-confirmed radiation necrosis. One patient died of recurrent grade II astrocytoma almost 15 years after her initial diagnosis.

The majority of deaths (83%) were due to a malignant transformation to a high-grade glioma (15 patients, 50%) or recurrent low-grade glioma (10 patients, 33%). There was only one postoperative death. An autopsy was performed on three patients (an astrocytoma grade IV was noted in two and an oligodendroglioma in one).

There was no significant difference in mean survival in those patients with grade I or II astrocytoma, in the extent of surgical resection i.e. total vs. subtotal vs. biopsy, or in those individuals with incomplete resection alone compared to those with postoperative radiotherapy (Table 3). Age was the most significant factor predicting survival. Patients under age 40 had a significantly longer mean survival than those age 40 or greater (59.6 months vs. 30.4 months, $p = .003$).

Discussion

The optimal treatment of low-grade astrocytomas remains to be defined. Surgery alone is generally ineffective therapy, although in some studies (5), patients who had total resection had better survival than those with subtotal resection, particularly those with pilocytic astrocytomas or children with cerebellar lesions (6,7).

Table 3 (5,7,8,9,10,11,12,13) summarizes the results of surgery only for low-grade cerebral astrocytomas. Five-year survivals are in the range of 0% to 34% for most series except that reported by Uihlein and colleagues (13) in which surgery only yielded a five-year survival rate in 17 patients (65%). Numerous retrospective studies

Table 3. Survival related to patients' age, tumor, grade and extent of surgery and radiotherapy

Parameter	*Mean No.*	*Survival Months*	*P Value*
Tumor Histology			
Grade I	10	50.5	
Grade II	28	40.5	.72
Age			
< 40 Years	19	59.6	.003
≥ 40 Years	19	30.4	
Surgery			
Total	8	50	
Subtotal	24	41	.41
Biopsy	6	33	
Radiotherapy*			
Yes	16	49.3	1.00
No	8	53.0	

Table 4. Results of surgery alone for low-grade cerebral astrocytomas

		EXTENT OF SURGERY			
Series	*Number*	*Biopsy Only*	*Subtotal Resection*	*Total Resection*	*5-Year Survival*
Laws et al[5]	167		Not Stated		34%
Garcia et al[7]	23	-	17	6	21%
Olmstead and Plenk[8]	5	3	-	2	No Survivors at 4 Years
Stage and Stein[9]	17	7	10	-	0-20%
Sheline et al[10]	37	-	37	-	19%
Bouchard[11]	42	-	13	29	26%
Fazekas[12]	15	-	15	-	13%
Uihlein et al[13]	17		Not Specified		65%

(Table 4) (5,7,8,9,19) suggest that varying doses of irradiation will prolong survival in patients with subtotal tumor removal. For primarily cerebral lesions, five-year survival figures range between 30%-60%. The 10-year survival figures are only in the range of 25%-35% (7,10,12,19).

Many of these studies, however, such as the present one, compare patients treated in different decades. Over the past decade, CT and MRI scanning may have improved the ability to find these lesions earlier and have assisted in operative planning and postoperative management. This is suggested by the fact that a greater percentage of completed resected lesions are reported in more recent studies (i.e. since 1980) than in earlier studies (20). In our series, seven of the eight patients who had a complete resection were diagnosed after 1980 by CT scan.

Technical factors related to radiation therapy are difficult to evaluate in terms of their impact on survival. Localized fields have been used almost exclusively for low-grade astrocytomas. No clear dose-response data exists, although most series have used doses in the 4,500 cGy-6,000 cGy range. There has been a trend towards higher doses in more recent years and suggestion that increasing doses improves local control (12), but retrospective series with varied patient populations make conclusions difficult. Many older studies have even suggested a survival disadvantage to high doses of irradiation (13,16).

Despite the fact that no difference in mean survival was demonstrated between the irradiated and non-irradiated patients with incompletely resected tumors in this report, it is premature to conclude that radiotherapy has no value. Since the role of radiotherapy, its dose, and the optimal timing of treatment is unclear, prospective randomized studies have recently been started in North America and Europe.

An Eastern Cooperative Oncology Group (ECOG) and North Central Cancer Treatment Group (NCCTG) study is comparing moderate dose (i.e. 5,040 cGy/28 fractions/5 1/2 weeks) and high dose (6,480 cGy/36 fractions/7 weeks) localized radiation with the hypothesis that higher doses will lead to better local control and survival. A European Organization for Research and Treatment of Cancer (EORTC) study is comparing moderate dose (4,500 cGy/25 fractions) and higher dose (5,940 cGy/33 fractions) radiation, in those with incompletely resected low-grade gliomas. A third study is underway by a Brain Tumor Cooperative Group (BTCG) and Radiation Therapy Oncology Group (RTOC) which compares surgery and immediate radiotherapy (i.e. within three weeks of surgery to surgery and delayed radiotherapy (i.e. for recurrent tumors or symptoms.)

The results of this study support the finding that age is an important variable in predicting survival (5,20,21,22). Laws and colleagues (5) found this to be true in 461 patients ($p < 0.0002$). The wide range of five-year survivals reported in the literature may largely reflect the variable number of younger patients (i.e. age 40 or younger) in each study. This observation strongly suggests that these tumors have an age-dependent variation in their biological activity. The reasons for this remain unknown.

The principal pattern of failure for low-grade gliomas is local. Reasons for local failures can be attributed to surgical factors (suboptimal debulking), radiation factors (in adequate dose and/or geographical miss), or the natural history of these neoplasms. Histologically, a recurrent lesion may return to its original grade or may undergo de-differentiation. In this series, there were 27 patients with recurrent tumor documented either at subsequent surgery or at autopsy. A change to astrocytoma grade III or IV occurred in 15 of these patients (57%). The incidence of such upgrading ranges from 30%-80% of patients rebiopsied in other clinical series or autopsied (1,5,6,23). It is also possible that a de-differentiated lesion may actually represent progression of a higher grade lesion which was missed on initial biopsy due to sampling error. With the more common use of stereotactic biopsy, mixed grade astrocytomas may become a more common phenomenon.

Patients' quality of life and functional capacities have rarely been mentioned in previous studies. North and co-authors (18) addressed this issue in a study of 66 patients with grade I and II astrocytoma diagnosed and treated with surgery and radiotherapy (5,000 cGy-5,500 cGy) between 1975 and 1985. Quality of life was determined at two points in time: 1 to 2 years postoperatively and at last follow-up (2-12 years postoperatively). The occurrence of mental retardation was specifically addressed in long-term survivors and was observed in 50% of the children. Overall, however, 80% of short-term survivors and 67% of long-term survivors were intellectually and physically intact, without major neurologic deficit. In our study, there was no assessment made of post-treatment long-term quality of life and this would clearly be important in any future study in a disease with relatively long survival and known treatment morbidity.

Table 5. Results of surgery (biopsy or subtotal resection) plus postoperative radiotherapy for low-grade cerebral astrocytoma

Series	*Number*	*5-Year Survival %*
Laws et al[5]	74	49
Marsa et al[6]	40	41
Garcia et al[7]	57	50
Olmsted and Plenk[8]	10	50
Stage and Stein[9]	28	28-40
Shelline et al[10]*	71	46
Bouchard[11]	105	49
Fazekas[12]*	32	41
Uihlein et al[13]	31	54
Rutten et al[14]	20	35
Silverman and Marks[15]	22	58-65 (4 Years)
Scanlon and Taylor[16]*	134	58-76
Shaw et al[17]	24	40 (Excluding Pilocytic Astrocytomas)
North et al[18]	66	55
Whitton et al[19]*	60	36

*Good Prognosis Lesions Included in Analysis (Primarily Childhood Cerebellar Tumors or Pilocytic Astrocytoma)

In summary, although the five-year survival of our patients seems comparable to other studies, it remains somewhat limited on a long-term basis. Since the role of chemotherapy, its dose, and the optimal timing of treatment in such a relatively rare tumor is still unclear (24,25), it is important that as many patients with low-grade gliomas as possible be included in clinical trials addressing not just survival but quality of life and treatment morbidity.

References

1. Russell DS, Rubinstein LJ. Pathology of tumors of the nervous system, 5th edition. The Williams and Wilkins Company, 1989.
2. Schoenberg BS. Epidemiology of primary nervous system neoplasms. In: Schoenberg BS, editor. Advances in neurology. New York: Raven Press, 1978;19:475-95.
3. Kernohan JW, Mabon RF, Svein JH, et al. Symposium on new and simplified concept of gliomas. A simplified classification of the gliomas. Proceedings of the Mayo Clin Staff Meeting; 1949;24:71-5.
4. Nelson JF, Tsukada Y, Schoenfeld D, et al. Necrosis as a prognostic criterion in malignant supratentorial, astrocytic glioma. Cancer 1983;52:550-4.
5. Laws ER, Taylor WF, Clifton MB, Okazaki H. Neurosurgical management of low-grade astrocytoma of the cerebral hemisphere. J Neurosurgery 1984;61:665-73.
6. Marsa GW, Goffinet DR, Rubenstein LJ, Bagshaw MA. Megavoltage irradiation in the treatment of glioma of the brain and spinal cord. Cancer 1975;36:1681-9.
7. Garcia DM, Fulling KH. Juvenile pilocytic astrocytoma of the cerebrum in adults. J Neurosurg 1985;63:382.
8. Olmstead CM, Plenk H. Radiation therapy of astrocytomas grades I-IV (abstract). Int J Radiat Oncol 1978;4:279.
9. Stage WS, Stein JJ. Treatment of malignant astrocytomas. Radiology 1974;120:7-18.
10. Leibel SA, Sheline GE, Wara WM, Boldrey EB, Neilsen SL. The role of radiation therapy in the treatment of astrocytomas. Cancer 1975;35:1551-7.
11. Bouchard J. Effects of irradiation in treatment of intracranial gliomas - treatment results by histologic groups. In: Bouchard J, editor. Radiation therapy of tumors and disease of the nervous system. Philadelphia, 1966:78-118.
12. Frazekas JT. Treatment of grades I and II brain astrocytomas - the role of radiotherapy. Int J Radiat Oncol Biol Phys 1977;2:661-6.
13. Vihlein A, Colby MY, Layton DD, Parsons WR, Carter TL. Comparison of surgery and surgery plus irradiation in the treatment of supratentorial gliomas. Acta Radiol (Ther) 1968;5:67-78.
14. Rutten EHJM, Kazem I, Slooff JL, Walder AHD. Postoperative radiation therapy in the management of brain astrocytomata - retrospective study of 142 patients. Int J Radiat Oncol Phys 1981;7:191-5.
15. Silverman C, Marks JE. Prognostic significance of contrast enhancement in low-grade astrocytomas of the adult cerebrum. Radiology 1981;139:211-3.
16. Scanlon PW, Taylor WF. Radiotherapy of intracranial astrocytomas - analysis of 417 cases treated from 1980 through 1969. Neurosurgery 1979;5:301-8.
17. Shaw EG, Scheithauer BW, Gilbertson DT, Nichols DA, Laws ER, et al. Postoperative radiotherapy of supratantorial low-grade gliomas. Int J Radiat Oncol Biol Phys 1989;16:663-8.
18. North CA, North RB, Epstein JA, Piantadosi S, Wharam MD. Low-grade cerebral astrocytomas: Survival and quality of life after radiation therapy. Cancer 1990;66:6-14.
19. Whitton AC, Bloom HJC. Low-grade glioma of the cerebral hemispheres in adults: A retrospective analysis of 88 cases. Int J Radiat Oncol Biol Phys 1990;18:783-6.
20. Piepmeier JM. Observations on the current treatment of low-grade astrocytic tumors of the cerebral hemispheres. J Neurosurg 1987;67:177-81.
21. Cohandon F, Aouad N, Rougier A, et al. Histologic and non-histologic factors correlated with survival time in supratentorial astrocytic tumors. J Neuro Oncol 1985;3:105-11.
22. Weir B, Grace M. The relative significance of factors affecting postoperative survival in astrocytomas, grades one and two. Can J Neuro Sci 1976;3:47-50.
23. Sheline GE. Therapeutic irradiation and brain injury. Int J Radiat Oncol Biol Phys 1980;6:1215.
24. Shaw EG. Low-grade gliomas. To treat or not to treat? A radiation oncologist's viewpoint. Arch Neurol 1990;47:1138-9.
25. Cairncross JG, Laperriere NJ. Low-grade gliomas: To treat or not to treat? A reply. Arch Neurol 1990;47:1139-40.

Indications for carotid endarterectomy

HOWARD H. KAUFMAN, M.D.
Professor and Chairman, Department of Neurosurgery, West Virginia University School of Medicine, Morgantown
JOSEPH L. VOELKER, M.D.
Assistant Professor, Department of Neurosurgery, West Virginia University School of Medicine, Morgantown

Abstract

Stroke is a major health problem in the United States. Carotid endarterectomy has been performed to prevent stroke in symptomatic and asymptomatic patients with carotid atherosclerosis.

The rationale for this approach has been questioned recently and several studies were begun to determine the proper role of surgery. The initial results from studies of symptomatic patients demonstrate that surgery is urgently indicated if stenosis is at least 70%, but not if it is less than 30%. Patients with intermediate amounts of stenosis are still being evaluated. Early evidence suggests that surgery is not indicated for asymptomatic patients, but two major trials are still in progress. Surgeons performing this procedure must demonstrate low perioperative morbidity and mortality. In addition, the use of ultrasound as a screening procedure is being re-evaluated.

We suggest rapid referral and evaluation of symptomatic patients with angiography, and treatment of asymptomatic patients with aspirin.

Introduction

After heart disease and cancer, stroke is the third leading cause of death in the United States. Fifty people per 100,000 population have a transient ischemic attack (TIA) every year, and 200 per 100,000 have a stroke. The cost in terms of disability, death and money is enormous (1).

A TIA occurs prior to atherothrombotic cerebral infarction in 50% of the cases and is commonly considered a warning sign for a future stroke (2). TIAs include temporary ischemic dysfunction of a cerebral hemisphere and transient monocular blindness (amaurosis fugax). They last most commonly for less than one or two hours. An episode lasting longer than 24 hours but completely resolving within one to two weeks is termed a reversible ischemic neurologic deficit (RIND) (2). More recently, however, any deficit more than 24 hours duration has been felt to reflect infarction (3).

A carotid endarterectomy was first successfully done in 1956 (4). Early use of the procedure was for the treatment of ischemic infarction due to carotid occlusion. It was found that revascularization of an acute infarction could have catastrophic results by causing hemorrhage into the infarcted brain. The operation thus came to be used mainly to prevent stroke in patients with TIAs, with good recovery from stroke, or with asymptomatic carotid stenosis. There was a steady growth in enthusiasm for the procedure, with a peak of over 107,000 operations at non-VA hospitals in 1985 (5).

Questions have been raised about the natural history of symptomatic carotid disease (6), the benign course of asymptomatic disease (7), high complication rates from surgery (8), and the use of aspirin to decrease the risk of stroke. As a result, there was a decrease in the performance of carotid endarterectomies to about 83,000 in non-VA hospitals in 1986 (5), and even fewer since then. Articles and editorials in prestigious journals suggested that carotid endarterectomy should not be employed for asymptomatic and even symptomatic carotid atheromas.

In an attempt to determine the role of carotid endarterectomy for patients with symptomatic and asymptomatic carotid atherosclerosis, several randomized prospective studies were begun in the 1980s. They were designed to define the natural history of carotid atheromas and the benefits and risks of surgery compared to aspirin therapy. The results of several of these studies, especially those of symptomatic disease, have now been published and are the subject of this paper.

Symptomatic carotid atherosclerosis

Three studies, the North American Symptomatic Carotid Endarterectomy Trial (NASCET) (9), the European Carotid Surgery Trial (ECST) (10), and the VA Cooperative Studies Program #309 (VA309) (11), deal with symptomatic carotid disease and have been at least partially completed and reported. All the patients in these trials, including those operated upon and those not, received aspirin and treatment for co-existing medical conditions.

The NASCET group was the first to release part of their results (12). This study enrolled symptomatic patients who had stenosis of at least 30% up to 120 days after an ischemic event. Stenosis was defined as the percent narrowing of the diameter of the vessel at the level of tightest stenosis compared to the diameter of the normal artery distal to the carotid bulb.

The research involving 659 patients with stenosis greater than 70% was stopped early when it became clear that the results were conclusive. Findings included a rate of ipsilateral stroke at two years of 9% in patients having surgery versus 26% in the patients who did not undergo operations. (Table 1). The rate of major and fatal ipsilateral strokes was 2.5% in surgical patients and 13.1% in non-surgical patients. The rate of any major stroke or death was 8% in surgical patients and 18.1% in non-surgical patients. Few strokes occurred in the surgical patients after one month. The peri-operative morbidity and mortality was 5%, with 0.6% deaths and 2.1% major strokes in surgical patients compared to a 3% morbidity/mortality rate at one month in non-surgical patients.

Another finding was that at two years, the non-surgical patients had experienced 26% ipsilateral strokes, 28% strokes in all distributions, and 31% stroke and death -- a far higher incidence than had been expected. This showed that the natural history of

Table 1. Risk of cerebral ischemia in symptomatic severe carotid stenosis

	Surgical	*Non-Surgical*
NASCET[a]	9%	26%
ECST[b]	12.3%	21.9%
VA309[c]	7.7%	19.4%

[a] Risk of any fatal or non-fatal ipsilateral stroke by 24 months after randomization
[b] Risk of surgical death, surgical stroke, ipsilateral ischemic stroke, or any other stroke by 3 years after randomization
[c] Risk of ipsilateral stroke or crescendo TIAs by 11.9 months after randomization

symptomatic carotid disease is worse than previously thought. Patients with stenosis between 30% and 69% are still being studied. Extrapolations have suggested that patients with stenosis of less than 50% do not benefit by endarterectomy.

The next study released was ECST (10). Of 778 patients with severe (70%-99%) stenosis, 12.3% of those undergoing the operation had not suffered any stroke or surgical death by three years after surgery, whereas 21.9% had if they had not undergone the operation (Table 1). Surgery diminished the incidence of ipsilateral stroke significantly and was especially beneficial if the endarterectomy was done early. In addition, there was no advantage for surgery over aspirin in patients with stenosis less than 30%; and those with stenosis between 30% and 69% are still being studied.

VA#309 (11) was also stopped early after 189 men with symptomatic stenosis greater than 50% were studied and it was found that the results were significant. At one year, the incidence of stroke or crescendo TIAs was 7.7% in those who underwent surgery, but 19.4% in those individuals not having the procedure (Table 1). It was felt that the effect was more significant in patients with stenosis greater than 70%. The perioperative stroke rate was 2.2% and mortality 3.3% for a total of 5.5%. The other issue addressed by the study was the accuracy of ultrasound. The authors noted that ultrasound underestimates the degree of narrowing for intermediate amounts of stenosis, that is in patients in whom an accurate measurement of stenosis is critical to determine whether or not surgery is appropriate.

Asymptomatic carotid atherosclerosis

Studies were also recently started on asymptomatic disease. These four research projects included the Mayo Asymptomatic Endarterectomy Trial (MACE) (13); Carotid Artery Stenosis With Asymptomatic Narrowing/ Operation vs. Aspirin (CASANOVA) (14); the VA Cooperative Studies Program #167 (VA 167) (15); and the Asymptomatic Carotid Atherosclerosis Study (ACAS) (16).

The MACE study (13), in which carotid endarterectomy was being compared to aspirin, was ended after 150 patients were entered. The study was stopped because those patients in the endarterectomy group and not receiving aspirin, had a high incidence of myocardial infarction. There were insufficient numbers to determine whether carotid endarterectomy was appropriate.

The results of CASANOVA have been published (14) and it was felt that carotid endarterectomy was not useful in 410 patients with stenosis between 50% and 90%. However, the study involved discretionary randomization and late surgery which considerably weakened it. It had a very complex protocol with multiple arms and indeed is quite difficult to read. A subsequent critique (17) suggested this study determined that early prophylactic endarterectomy did not diminish the incidence of strokes.

VA#167 (15) closed its enrollment of patients with stenosis of at least 50% in 1988, but is continuing to accumulate data. Preliminary analysis of this study suggests a possible trend favoring surgical intervention in some patients. It is felt that the study may not be ultimately definitive (Mayberg, personal communication).

The definitive study regarding the treatment of asymptomatic disease will be ACAS. Already, 1,200 of 1,500 anticipated patients with stenosis of at least 60% have been entered into this study and enrollment may be finished by the end of 1992. A final report is expected to be completed in two to three years.

Conclusions

These studies indicate that symptomatic patients who have carotid stenosis greater than 70% should have carotid endarterectomy. Optimally, this should be done early since devastating strokes tend to occur early.

Indeed, it has also been found that the natural history in those patients who do not have surgery, in terms of stroke and death, is much worse than had been previously suggested. These adverse outcomes tend to occur early, which balances some of the surgical perioperative risk. However, the endarterectomy must be performed by surgeons who can demonstrate a morbidity and mortality rate of below 5%, or the surgical risk is too high to warrant operation (Mayberg - personal communication). Unfortunately, recent studies have suggested tremendous variations in morbidity and mortality, which is thought to average 10% in the United States (9). These variations, though, may relate not only to surgical skills, but also to the characteristics of patients who were having the operations.

Additionally, as indicated by VA #309 (11), use of carotid ultrasound is problematic. Technical problems can create artifacts (18), and machines vary greatly in accuracy (19), so reliability is less than ideal. Due to the fact that there is considerable variation in accuracy among ultrasound laboratories, the authors recommend that the accuracy of all laboratories be verified against angiography before the results be used, and that there be ongoing quality control.

Regarding asymptomatic carotid disease, CASANOVA was suggestive, but not conclusive that surgery is not indicated in patients who have stenosis of less than 90%. VA #167 suggests a trend favoring surgery, but may never be definitive. The answer may not really be known until the results from ACAS are available. There may be certain patients such as those with very high grade stenosis, progressively increasing stenosis, or large ulcers who may be candidates for surgery, but only if the surgeon has a morbidity/mortality rate of less than 3% (11). Such circumstances may be rare.

A recent estimate suggests the current cost for carotid endarterectomy in the United States is $2 billion annually, and two thirds of this amount is for surgery based on indications which are today unproven (20). However, at the conclusion of all ongoing studies on symptomatic and asymptomatic patients, the answer to the 35-year-old question of which patients should and which patients should not be submitted to carotid endarterectomy will be definitively answered once and for all (21).

In conclusion, we feel that patients with transient cerebral or retinal ischemia or who suffer mild strokes or strokes which largely resolve, should be considered to have an urgent problem and should be referred quickly for evaluation. If this diagnosis is entertained, angiography should be used to confirm the presence and amount of carotid stenosis. Early carotid endarterectomy is recommended for symptomatic patients with stenosis of more than 70%. We advise that carotid endarterectomy be employed in asymptomatic patients with stenosis less than 90% only in very rare situations until further information is available from ACAS.

References

1. Operating to prevent stroke (editorial). Lancet 1991;337:1255-6.
2. Toole JF. Cerebrovascular Disorders. 4th ed. New York: Raven, 1990:129-50.
3. Mohr JP, Gautier JC, Pessin MS. Internal carotid artery disease. In: Barnett HJM, Mohr JP, Stein BM, Yatsu FM, editors. Stroke: pathophysiology, diagnosis and management, 2nd ed. New York: Churchill Livingstone, 1992;285-336.
4. Cooley DA, Al-Naaman YD, Carton CA. Surgical treatment of arteriosclerotic occlusion of common carotid artery. J Neurosurg 1956;13:500-6.
5. Pokras R, Dyken ML. Dramatic changes in the performance of endarterectomy for diseases of the extracranial arteries of the head. Stroke 1988;19:1289-90.
6. Kernan WN, Feinstein AR, Brass LM. A methodological appraisal of research on prognosis after transient ischemic attacks. Stroke 1991;22:1108-16.
7. Chambers BR, Norris JW. Outcome in patients with asymptomatic neck bruits. N Engl J Med 1986; 315:860-5.
8. Till JS, Toole JF, Howard VJ, Ford CS, Williams D. Declining morbidity and mortality of carotid endarterectomy. The Wake Forest University Medical Center Experience. Stroke 1987;18:823-9.
9. North American Symptomatic Carotid Endarterectomy Trial (NASCET) Steering Committee. North American Symptomatic Carotid Endarterectomy Trial. Methods, patient characteristics, and progress. Stroke 1991;22:711-20.
10. European Carotid Surgery Trialists; Collaborative Group. MRC European Carotid Surgery Trial: Interim results for symptomatic patients with severe (70-99%) or with mild (0-29%) carotid stenosis. Lancet 1991;337:1235-43.
11. Mayberg MR, Wilson SE, Yatsu F, Weiss DG, Messina L, Hershey LA, et al. Carotid endarterectomy and prevention of cerebral ischemia in symptomatic carotid stenosis. JAMA 1991;266:3289-94.
12. North American Symptomatic Carotid Endarterectomy Trial Collaborators. Beneficial effect of carotid endarterectomy in symptomatic patients with high-grade carotid stenosis. N Engl J Med 1991; 325:445-53.
13. Mayo Asymptomatic Carotid Artery Study Group. Results of a randomized controlled trial of carotid endarterectomy for asymptomatic carotid stenosis. Mayo Clinic Proc 1992;67:513-8.
14. The CASANOVA Study Group. Carotid surgery versus medical therapy in asymptomatic carotid stenosis. Stroke 1991;22:1229-35.
15. Towne JB, Weiss DB, Hobson RW III. First phase report of cooperative Veterans Administration asymptomatic carotid stenosis study - operative morbidity and mortality. J Vasc Surg 1990;11:252-9.
16. Howard G, Jones AM, Chambless L, Baker W, Ricotta JJ, O'Leary D, et al. A multicenter validation of Doppler ultrasound versus angiogram: the ACAS experience (abstract). Stroke 1991;22:147.
17. Solis MM, Ranval TJ, Barone GW, Eidt JF, Barnes RW. The CASANOVA Study. Immediate surgery versus delayed surgery for moderate carotid artery stenosis? (letter to the editor). Stroke 1992;23:917.
18. Council on Scientific Affairs. Medical diagnostic ultrasound instrumentation and clinical interpretation. Report of the Ultrasonography Task Force. JAMA 1991; 265:1155-9.
19. Howard G, Chambless L, Baker W, Ricotta JJ, Jones AM, O'Leary D, et al. A multicenter validation study of Doppler ultrasound versus angiography. J Stroke Cerebrovasc Dis 1991; 1:166-73.
20. Barnett HJM, Barnes RW, Clagett GP, Ferguson GG, Robertson JT, Walker PM. Symptomatic carotid artery stenosis: a solvable problem. North American Symptomatic Carotid Endarterectomy Trial. Stroke 1992;23:1048-53.
21. Reinmuth OM, Dyken ML Jr. Carotid endarterectomy: bright light at the end of the tunnel. Stroke 1991;22:835-6.

New Manuscript Guidelines

All scientific manuscripts should be submitted on disc in the following languages: Wordperfect 4.2, 5.0, and 5.1; Word; Word for Windows; and WordStar. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

No more than 25 references will be published free of charge and they must be presented in the style based on the formats used by the U.S. National Library of Medicine in *"Index Medicus."*

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Nd:YAG laser surgery of venous malformations

ROMEO Y. LIM, M.D., F.A.C.S.
Chief of Surgery, The Eye and Ear Clinic of Charleston, Inc.; and Clinical Professor of Otolaryngology Head and Neck Surgery and General Surgery, WVU Health Sciences Center, Charleston Division/Charleston Area Medical Center

Abstract

Venous malformations are prevalent in the head and neck. These anomalies are difficult to eradicate by conventional methods due to excessive bleeding and imprecise excision. This article details how the success rate for treating low flow venous malformations was 100% in 24 patients who underwent Nd:YAG surgery.

Introduction

Venous anomalies of the head and neck are a challenge to treat because of their vascularity and high recurrence rate. Various therapeutic methods such as surgical resection, embolization, electrocautery, cryotherapy, and steroid and sclerosing agent injections have been used to treat these lesions. The majority of these lesions regress by the time an individual is seven years old, but complications such as bleeding, infection, ulceration, pain and deformity may require early treatment.

The CO_2 and Argon lasers are effective for localized and superficial vascular lesions of the skin (1-3). For the deeper type, the non-contact Nd:YAG laser is more effective because of its deeper penetration and selective absorption (4). This paper reports our experience with the non-contact Nd:YAG laser photoablation of venous malformations in the head and neck.

Table 1. Site of lesions

Site	*Number (24)*
Pinna	2
Tongue	5
Lip	6
Nose	1
Buccal mucosa	4
Larynx	2
Palate	4

Materials and methods

Between 1988 and 1992, 24 patients with venous malformations of the head and neck were treated using the SLT Nd:YAG (Oakes, Pa.) laser system (5). The youngest patient was 2 months and the oldest 78 years. The sites are listed in Table 1.

The size of the lesions varied from 1 cm. to 6 cm. The laser power setting was at 20-24 watts continuous mode and was delivered through a 2.2 mm. fiberoptic cable at a distance of 5 mm. For the bulky lesions, a glass slide was used to compress the lesions to about one cm. (6). Blanching or dessication of the tumor surface is noted when an effective photoablation is achieved. For lesions larger than 2 cm., repeat laser applications are required at four-month intervals. Crusting and drainage of the tumor are noted after lasing and may be present for two months. Hydrogen peroxide cleansing and antibiotic ointment application are effective in controlling infection. A 100% success rate was obtained in all cases with minimal scarring.

Illustrated case

A two-month-old baby girl was examined for a red lesion of the left pinna that was present at birth and had grown with recurrent bleeding and blisters. Examination showed a 3 cm. x 3 cm. cavernous hemangioma involving the lower half of the left pinna with ulcers and clots (Figure 1). The external auditory canal was clear.

Under general anesthesia, non-contact SLT Nd:YAG laser was applied through a 2.2 mm. fiberoptic cord at 20 watts and continuous mode without any bleeding. Complete regression was achieved after one year with three applications at four-month intervals, with minimal scarring and without deformity (Figure 2).

Discussion

Treatment of venous malformations in the head and neck is difficult because of their vascularity and intrusion into surrounding structures. Mulliken (7) classifies these into cavernous, capillary or combined malformations.

The Nd:YAG laser produces a continuous wave power output at 1064 nm. near the infrared spectrum and is invisible. This laser beam (non-contact) penetrates 5 mm. - 7 mm. of tissue, due to scattering and absorption specifically by vascular tissues. The laser beam by absorption is transformed into thermal energy that causes coagulation necrosis with hemostasis over a volume of 5 mm. - 7 mm. of tissue. Due to its specific absorption, tissue destruction is selective, so normal tissues are spared. For high blood flow type vascular

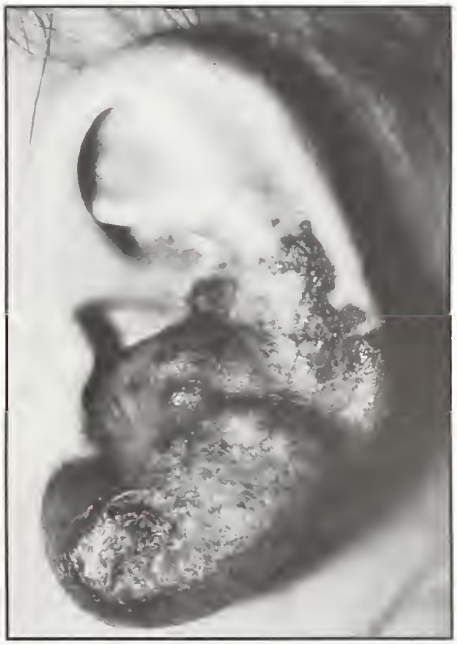


Figure 1. Cavernous hemangioma of the pinna.

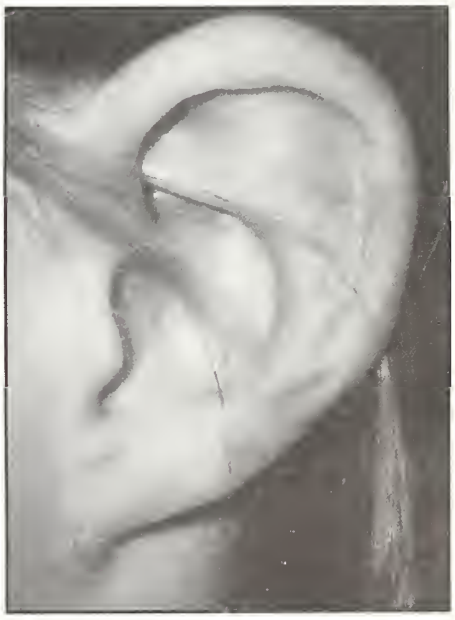


Figure 2. Complete regression.

malformations such as arterio-venous, the non-contact Nd:YAG laser is ineffective due to poor absorption and dissipation of laser energy.

Postoperative pain in these cases was absent or minimal even in the presence of swelling or necrosis. This may be explained on the basis that sensory nerve endings are not affected by the Nd:YAG laser since they are white. To minimize severe necrosis and sloughing, a minimum effective power setting of 20 watts - 30 watts is used and applied in a polka-dot manner (gapping). In large lesions, multiple applications are required at 4 month - 6 month intervals using both the non-contact and contact modes (8). The Nd:YAG laser system can be delivered through an endoscope in treatment of airway and gastrointestinal vascular lesions. Due to its excellent hemostasis, prophylactic tracheostomy is obviated in ablation of a subglottic hemangioma.

Summary

The non-contact Nd:YAG laser system is well absorbed by low flow venous malformations causing coagulation necrosis and selective tissue destruction. Understanding of laser biophysics and histopathology is important for successful management of venous malformations.

Acknowledgement

The author wishes to thank Mary Jane Willis, P.A., for assisting with the preparation of this manuscript.

References

1. Healy GB, McGill T, Friedman EM. Carbon dioxide laser in subglottic hemangioma. An update. Ann Otol Rinol Laryngol 1984; 93:370-3.
2. DiBartolomeo JR. Response of vascular lesions of the head and neck to argon laser radiation. Otolaryngol Head Neck Surg 1983;91:203-8.
3. Apfelberg DB, Maser MR, Lash H, White DN. Benefits of the CO_2 laser in oral hemangioma excision. Plast Reconstr Surg 1985; 75:46-50.
4. Rosenfield H, Sherman R. Treatment of cutaneous and deep vascular lesions with the Nd:YAG laser. Lasers Surg Med 1986; 6:20-3,50-1.
5. Lim RY, Willis MJ, Contact Nd:YAG laser for soft tissue surgery. WVa Med J 1991; 87: 246-9.
6. Rebeiz E. April MM, et al. Nd:YAG laser treatment of venous malformations in the head and neck. Otolaryngol Head and Neck J 1991;105:655-61.
7. Mulliken JB. Classification of vascular birthmarks. In: Mulliken JB, Young AE, editors. Vascular birthmarks: hemangiomas and malformations. Philadelphia: WB Saunders Co., 1988:24-37.
8. Daikuzono N, Joffe SN. Artificial sapphire probe for contact photocoagulation and tissue vaporization with Nd:YAG laser. Med Instrum 189 (4) July-August 1985.

West Virginia Academy of Otolaryngology

Head and Neck Surgery, Inc.

You are invited to attend the annual spring meeting of the

West Virginia Academy of Otolaryngology - Head and Neck Surgery, Inc.

The Greenbrier, White Sulphur Springs, WV
May 28 - 31, 1993

***Registration Fee*: $150**
***Apply to*:**
F. Thomas Sporck, M.D.
Post Office Box 1628
Charleston, WV 25326-1628

***Guest Speakers*: Lee D. Eisenberg, M.D., F.A.C.S.**
John K. Niparko, M.D.
Harold C. Pillsbury, III, M.D., F.A.C.S.

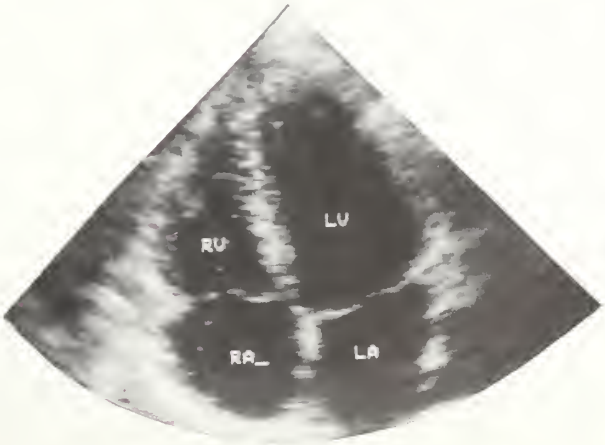
AMA Credit Category I, 12 Hours Otolaryngology

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time

SOUND



Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

President's Page

Robert P. Pulliam MD.

??????????????

Medicaid is a program which primarily provides health care for the poor. Since its inception, it has been funded by general revenue dollars, and, as with almost all other public programs, was chronically underfunded from the start.

In 1992, because of a quirk in federal law, health care providers were asked by the Legislature to assist in improving reimbursements by paying a tax on Medicaid receipts. The major impetus from the state's viewpoint was a lawsuit which pointed out that provider payments were so low that access to care was inhibited. The tax that was devised, called the Medicaid Enhancement Tax, was essentially a Ponzai scheme. It used the same dollar over and over to repeatedly obtain federal matching funds on a 3 to 1 basis. The feds quickly became aware of the scheme and stopped it effective July 1, 1993. (The state, however, quickly expanded programs and paid providers more for services.)

Access to care for Medicaid recipients was increased as was cost. For example, the Public Employees Insurance Board insures 194,182 people with an average cost of $1,307 per person. Medicaid at the same time spent $4,276 per person. Administrative cost per covered person was also divergent -- PEIA $77, Medicaid $340.

Providers received increased payments that approximated 57% of their usual and customary fee, up from 33%, hardly a windfall. Physicians have been caring for Medicaid patients for many years (in my case, 25+ years) at $5 to $10 per office visit. The payment increase did not eliminate the cost shift to any significant degree.

Now, the government leadership wants providers to fund health care for the poor by imposing a gross receipts tax. Gross receipts taxes do not take into account the cost of doing business. In many cases, if not all, individuals, i.e. providers will be paying more in gross receipts taxes than they pay in individual personal state income taxes. Alternative taxes are available, but the legislative leadership view them as untenable. A suggested surtax of 23% on individual income tax would cost 97% of West Virginians less than $1 per day, and individuals paying tax on under $20,000 would pay only 41¢ per day.

Several questions need to be answered. First, is society willing to provide health care for the Medicaid segment of society? If the answer is yes, then at what level? Currently, many Medicaid recipients are receiving total benefits equal to an annual income of $16,000. Should these benefits exceed those that working people are able to provide for themselves? Difficult questions and difficult answers.

Assume that society is willing and the benefits are defined, then what is the responsibility of the recipient? Consider that the Medicaid recipient's utilization is 160% of the non-Medicaid recipient. Should there be co-payments and deductibles? In addition, what about lifestyles? Should there be restrictions or requirements in that area?

Finally, we should approach the question of funding. Who is responsible for funding health care for Medicaid recipients? Is it society or providers?

If your answer is providers, consider an extension of this concept in future years -- taxing lawyers to provide legal aid for the poor -- taxing contractors to build homes for the homeless -- taxing teachers to provide education -- and on and on as the insatiable appetite of the government to expand is unrestrained.

Robert P. Pulliam, M.D.

Making sense

It just seems shameless to talk one day of carving $35 billion out of medical care costs from allegedly inflated physician and hospital charges, and then the next to attempt authorizing entry into the United States for several hundred HIV-positive Haitians held at Guantanamo Bay.

The last we heard, it costs someone at least $150,000 in medical care for every AIDS victim before death actually occurs. It wasn't really stated whether any of the Haitians had their HMO premiums paid up to date, but it is likely someone would have to pay for their dying before they had stayed long enough to become citizens, if that was ever their intent. In a rare display of good sense, the United States Senate declined to agree to the entry of these medical time bombs.

Along with the pitch to allow entry were nonsensical statements by medical "experts" who should be ashamed for suggesting that admitting HIV-positive immigrants would pose no threat to anyone in this country. Do they expect to get vows of celibacy from such new arrivals?

Statements were made that only tuberculosis created a public health hazard and only those with active tuberculosis should be excluded. Have they not begun to suspect that T.B. thrives in individuals with compromised immune systems and that AIDS in the community is responsible for the sometimes epidemic spread of T.B. in that community?

Yes, we are supposed to be humanitarian in treating all illnesses including those some might believe carry moral opprobrium. We are furthermore supposed to be unprejudiced about AIDS and its most common method of transmission because we might hurt someone's feelings by singling them out. The subject here, however, is dollars, not humanitarianism or prejudice. It just does not make sense to worry about the paucity of dollars to take care of existing medical care costs and simultaneously obligate the system with untold millions of dollars in additional expense.

A politician's need to make sense rarely influences one way or the other his or her need to generate votes. This is a sad observation, but true. Early moves of the Clinton administration make the observation seem alarmingly true.

– SDW

If elective abortion is not wrong, nothing is wrong

For years, the ethical issues involved in elective abortion could be ignored because the only individuals involved were the mother and developing baby. If a mother were driven to an abortion, sympathy was extended to the mother in her difficult position, but the determination of right or wrong could be left to a just but compassionate God when that mother died.

Unfortunately, medical research has progressed so far and so fast that the possibility of resultant harm on a vast scale has appeared. Perhaps, this was foreshadowed by Nazi Europe in the government-supported research of such people as Joseph Mengele, M.D. Now, in the United States, we are experiencing disturbingly similar scenes. U.S. doctors have randomly killed babies in the uterus to attain some "desirable" number of babies (1,2). The use of fetal tissue in research raises some points more in common with Boris Karloff than science. Genetic research soon, with its benefits, will also present us with a Pandora's Box of potential ethical horrors. The issues involved in elective abortion encapsulate the ethical issues raised in these other activities.

The pro-life position, in our opinion, rests on two basic human values. The first is that human life is somehow "sacred" -- that is, dedicated to and therefore accountable to God.

This statement reaches back into the remote history of westenr civilization. It is intrinsic in Orthodox Judaism. It was present in the Hippocratic Oath of 600 B.C. (3), and is at the core of Christianity. Pro-abortionists are indifferent to this issue. Their attitude is similar to that of certain medieval Christian crusaders attacking a town filled with heretics and Christians alike, "Kill them all and let God sort them out." Now, in the United States, a mother can kill her third trimester baby the day before it would be normally born and bear no penalty, and even no social stigma! So much for the sanctity of life.

The second basic human value which the pro-life position is based upon is that human life begins at conception.

The pro-abortion side argues that we cannot know when life truly begins. If this is true, how can they be so arrogant and stone-hearted as to advocate the killing of what may indeed be a living human?

This willingness to kill what may be a sacred life is the bedrock difference between the pro-life and pro-abortion sides. This difference has tremendous implications for the future of our society as we head into an era of increasing competition for scarce dollars. If we accept that there is no absolute moment when life begins, then there can be no absolute moment when life ends. If we are able to kill a viable third-trimester baby the day before its otherwise normal delivery, just because of the baby's unfortunate location in a certain woman's uterus, there is absolutely no logical reason why we can't "euthanize" some medically frail, elderly, comatose person just because of the bed he/she is lying in.

On the other hand, if scientists can determine that life ends when a person's body can no longer maintain its functional integrity (4), it stands to reason that life begins when that functional integrity is first constituted. In multicellular Earth life, the organism becomes whole when the genetic code becomes complete at the moment of conception. Therefore, for scientists, life begins at the moment of conception.

These two statements serve as guides for our interactions with society. We will describe them as first level principles.

The following two statements serve as guides for our interactions with individual persons and can be called second level principles:

1. The "Golden Rule" of -- "Do unto others as you would have them do unto you." This famous sentence does not suffice by itself. An amoral or immoral person would follow this rule and still do terrible acts. Therefore, we need a channel for this guide.
2. It is impermissible to use another person solely as a tool to benefit some other person.

These two principles are at the core of Kantian ethics (5). Kantian ethics is the driving force behind such important concepts as the need for the informed consent of patients. With the two levels of principles working together, abortion and such issues as the use of fetal tissue for research can be examined and their folly becomes clear.

Elective abortion is wrong at the first level. It is the unnecessary killing of a sacred human life. It is wrong at the second level. It is the killing of a human life, not because the life of the mother is threatened, but because the presence of the developing baby is an inconvenience to the mother. The response, killing the baby, is totally disproportionate to the harm done to the mother.

The use of fetal tissue from elective abortions for research is wrong at the second level. We are killing a human being for use as a tool to benefit another human being. This is the same reason slavery was outlawed and why scientific research without the informed consent of the research subjects is forbidden. Recently, there was a revealing controversy about using data from a Nazi doctor's research (6). Utilitarian arguments decried the loss of "valuable" research data, ignoring how it was obtained but -- "There is no right way to do a wrong thing!"

Wisdom is selecting the best choice from a variety of options. Wisdom does not require great intelligence. A child can be "wise beyond his/her years" in making decisions. Wisdom does require, as a base, a firm set of principles. Otherwise, we would constantly be shifting from one position to another and constantly shifting our decisions as our views changed. Wisdom does require an accurate awareness of our strengths, weaknesses, ignorance and areas of insecurity.

How many of us, had we been alive in 1933 in Germany, could have foreseen the Nazi death camps of 1943? How many of us can now foresee the events of 2003?

Today, it is quite common for amniocentesis to be used to determine if a developing baby has Down's syndrome. The affected baby is then aborted. In the near future, it will be possible to clone severely mentally deficient Marilyn Monroe look-alikes in a test tube. Do any of us wish to live in a society where these individuals could be used as sexual toys for a few years and then, when the first wrinkles appear or boredom sets in, have them shot or strangled, their bodies to be thrown into the garbage? The killing of developing babies in utero and the "euthanizing" of defenseless elderly people both are part of an ethical current carrying us toward this dreadful destination.

Where has the medical community been while we have allowed this situation to arise? Ethics can be learned. People can change their minds and their actions (7). The assumption of a leadership role by the medical community in teaching basic ethics to our fellow citizens is long and sadly overdue. Our delinquency in serving as the teachers and consciences for our ethically less educated fellow citizens is a tragedy and a condemnation.

References

1. Berkowitz RL, Lynch L, Chitkara U, Wilkins IA, Mehalek KE, Alvarez E. Selective reduction of multifetal pregnancies in the first trimester. N Engl J Med 1988;318:1043-7.
2. Diamond EF. Letter to the editor. N Engl J Med 1988;319:950.
3. Edelstein L. The hippocratic oath. Bulletin of the History of Medicine 1943;Supp 1:1-64.
4. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Deciding to forego life-sustaining treatment: a report on the ethical, medical, and legal issues in treatment decisions. Washington, D.C. The Commission, 1987.
5. Mappes TA, Zembatty JS. Biomedical ethics. 3rd ed. New York: McGraw-Hill, 1991.
6. Ziporyn T. What the Nazis called "medical research" haunts the scientific community to this day. JAMA 1990;263:791.
7. Nathanson BN. Sounding board - deeper into abortion. N Engl J Med 1974;291:1189-90.

Submitted by the Medical Advisory Board of the Raleigh County Chapter of West Virginians for Life:

Ted Solari, M.D.
William Scaring, M.D.
Sarah Loot, M.D.
Marcia Khalil, M.D.
Robert C. Belding, M.D.

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

Changes made in Annual Meeting format

To better accommodate the needs of all participants who will be attending the WVSMA's Annual Meeting, a variety of revisions have been made in the program's schedule, according to James L. Comerci, president-elect of the WVSMA.

"The major focus of the WVSMA's Annual Meeting is by necessity business and politics," Dr. Comerci said. "We have, though, continued to offer CME programs since many members attend the meeting for educational purposes. In addition, the length of the meeting, as well as the time interval between the two House of Delegates meetings, has made it difficult for many members to attend the entire meeting, so we felt it was time to try a new format," he added.

Highlights of the changes are as follows:

Wednesday, August 18

morning	Executive Committee meeting
afternoon	Council meeting

Thursday, August 19

morning	CME lectures
noon	Lunch and Learn (This is a new event which will offer CME credit in conjunction with a luncheon. An additional fee will be charged.)
afternoon	Tournaments Resolutions Committee

Friday, August 20

morning	**First Session of the House of Delegates** (CME will be included.)
noon	WESPAC luncheon (This is a new event which will offer CME credit in conjunction with a luncheon. An additional fee will be charged.)
afternoon	Meetings of the specialty societies

Saturday, August 21

morning	**Second Session of the House of Delegates** (CME will be included and elections will be conducted.)
afternoon	**Second Session continued** (Resolutions will be voted on and the officers will be installed.)

This year's meeting is jointly sponsored by the WVSMA and the West Virginia University School of Medicine, which is entitled by the Accreditation Council for Continuing Medical Education (ACCME) to award credits in continuing medical education for physicians.

The Lunch and Learn and the WESPAC luncheon will be the two new CME events at this year's meeting. Both of these programs will be open to all participants and their family members for a nominal fee.

The Lunch and Learn will feature a speaker on the topic of the physicians' role in reporting domestic violence cases, and roundtable discussions will be held on a variety of issues concerning this subject. The WESPAC luncheon is scheduled to have a panel of visiting state medical society presidents who will discuss the PACs in each of their own states.

"The new meeting format will hopefully allow the WVSMA to continue to offer CME, have maximum attendance at the House of Delegates, and minimize lost time in our practices," Dr. Comerci said. "I hope our members are pleased with this new schedule and that it encourages many physicians who have not attended in the past to participate."

A reservation form for this year's meeting is printed on page 99 and further details about the conference can be obtained by phoning Nancie Divvens at 925-0342.

Rural health conference set

The National Rural Health Association will conduct its 16th annual national conference, "Rural Health: Putting the Pieces Together," May 12-15, in Kansas City, Mo.

Rural Health:
Putting the Pieces
Together

National Rural Health Association
16th Annual Conference on Rural Health
May 12-15, 1993
Kansas City, Missouri

This conference is designed to develop skills and techniques in health services administration, organization and research; and present clinical sessions, policy issues and research results of interest to rural health providers. It is co-sponsored by the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Preventive Medicine, the Association of State and Territorial Health Officials, the federal Indian Health Service, and the National Clearinghouse for Primary Care Information.

For information, contact the NRHA at (816) 756-3140.

WVBPH assisting hospitals promote breastfeeding initiative

Many West Virginia hospitals and birthing centers are participating in the "Baby-Friendly Hospital Initiative," a voluntary global program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) to recognize hospitals that provide optimal care and support for breastfeeding mothers and babies.

To assist with this initiative, the West Virginia Bureau of Public Health/WIC Program is providing health care professionals and hospitals with the following educational programs and resources so they can better serve their breastfeeding patients:

- A team from the WV Bureau of Public Health and Women & Children's Hospital in Charleston is currently providing in-service programs to community hospitals statewide to assist them in adopting practices that best support their patients who choose to breastfeed.
- The WV Bureau of Public Health, with funding from federal MCH grant #MCJ-546037, will sponsor a lecture by Dr. Linda Black, a renowned breastfeeding advocate, at the WV American Academy of Pediatrics meeting on March 27 in Charleston.
- The WV Bureau of Public Health/WIC will sponsor the presentation "Creating a Baby-Friendly Hospital," by Connie Neuner, WV WIC Breastfeeding Program Coordinator, at the NAACOG meeting in March in Morgantown.

Hospitals interested in applying for a certificate of intent to support the BFHI or to schedule a breastfeeding promotion in-service program may contact Connie Neuner at 558-0030.

North Carolina physician requesting medical information

Claude A Frazier, M.D., an allergist in Asheville, N.C., would like for physicians who have any reports of deaths or near deaths from anaphylaxis due to food or insect allergy, or reports of incidents where death was prevented by the use of epinephrine kits, to write him at 4C Doctors Park, Asheville, N.C. 28801.

Mangus named chief of CAMC's medical staff

Mangus

Boland

Crotty

Jimmie L. Mangus, M.D., a family practice physician who is a clinical associate professor at the WVU Health Sciences Center, Charleston Division, has been elected chief of staff at the Charleston Area Medical Center.

Dr. Mangus is a graduate of WVU and the Medical College of Virginia, who completed his internship at CAMC. A charter fellow of the American Academy of Family Physicians, Dr. Mangus is board certified by the American Academy of Family Practice.

The other WVSMA members elected officers were James P. Boland, M.D., as chief of staff-elect, and Glenn Crotty Jr., M.D., as secretary-treasurer.

Hayes elected board chairman at Thomas

Hayes

Radiologist Thomas M. Hayes, M.D., has been named chairman of the board of trustees at Thomas Memorial Hospital in South Charleston.

The other WVSMA members serving on Thomas' board of trustees are Rodney D. Dean, M.D., and John Mani, M.D., who is president of the hospital's medical staff.

Family medicine course offers 52 CME credit hours

Family physicians will have the opportunity to earn up to 52 CME credit hours at "Advances in Family Medicine," an educational and recertification course sponsored by the Department of Family Medicine of the University of Cincinnati, May 1-7, at the Albert B. Sabin Convention Center in Cincinnati.

This conference features lectures, seminars and workshops on the latest technologies and issues facing primary care family physicians. Sessions offered will be presented by faculty members representing all departments of the University of Cincinnati College of Medicine, and will provide a review and update for those physicians certifying or recertifying for the American Board of Family Practice examination in July.

Advances in Family Medicine has been reviewed and approved for up to 52 CME credit hours by the American Academy of Family Physicians (AAFP), the American Osteopathic Association (AAO), and the Physician's Recognition Award of the American Medical Association.

To register or for more information, contact the UC Department of Family Medicine at (513) 558-4021.

Sixth annual ethics symposium scheduled for Morgantown

"The Right to Life -- The Right to Death" is the title of the Sixth Annual Symposium of the West Virginia Network of Ethics, which will be conducted on Friday, May 7 at the WVU Health Sciences Center in Morgantown.

Sponsored by the West Virginia Network of Ethics Committees and the Center for Health Ethics and Law, this symposium will present an update on the ethical and legal issues in withholding and withdrawing life-sustaining treatment; feature a debate between representatives of the National Right to Life Committee and the Hemlock Society; and apply the process of ethical decision-making to difficult cases involving sophisticated medical technology such as intensive care and in vitro fertilization.

For more details, phone 293-7618.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

The programs this month were compiled by: Nancie Divvens, associate executive director for the West Virginia State Medical Association; Robin Rector, coordinator for CME for Charleston Area Medical Center; and Kari Long, program director of CME and rural services for WVU.

More details about these CME activities may be obtained by calling Divvens at 925-0342; Rector at 348-9580; and Long at 293-3937.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

May 1 - First Generation Loss Control Seminar, South Charleston

CAMC/WVU Health Sciences Center - Charleston

April 1 - "Skin Cancer/Radiation Therapy," (teleconference), WVU Health Sciences Center and Satellite locations

April 3 - "20th Annual Newborn Day," WVU Health Sciences Center Auditorium

April 6 - "Mini and Maxi Flaps for the General Surgeon," Ted Jackson, M.D., (sponsored by the WVU Dept. of Surgery and the Eye and Ear Clinic of Charleston, Inc.), 5:30 p.m., Faculty Lounge, 4th floor, WVU Health Sciences Center

April 15 - "Gynecological Laparoscopic Surgeries," (teleconference), noon, WVU Health Sciences Center and satellite locations

WVU Health Sciences Center - Morgantown

April 16 - "Stephen Rector Visiting Lectureship," WVU Health Sciences Center

April 24 - "Controversies in Geriatrics and the Roaring River," Lakeview Resort and Conference Center, Morgantown

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Fairmont ★ Fairmont General Hospital, April 4, 7:30 p.m., "Evaluation of Diarrhea Work-up," Ronald Gaskins, M.D.

Fairmont ★ Fairmont Clinic, April 21, 1 p.m., "The Role of the P.A. in Managing Aging Patients," Lori Stahara, M.D.

Gassaway ☐ Braxton County Memorial Hospital, April 14, 7 p.m., "Nephrology Update," Julian Espiritu, M.D.

Madison ☐ Boone Memorial Hospital, April 13, 6:30 p.m., "Skin Cancer," Brad Cohen, M.D.

Man ☐ Man Appalachian Regional Hospital, April 20, 7 p.m., "Domestic Violence," Ralph Smith, M.D.

Montgomery ★ Montgomery General Hospital, April 7, 12:15 p.m., "Non-Small Cell Carcinoma," Arvind Kamthan, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, March 31, 7 a.m., "Difficult Ethical Decisions in Medical Practice," Alvin Moss, M.D.

★ Camden-Clark Memorial Hospital, April 14, 7 a.m., "Vascular Tumors of the Head and Neck," Mark Wax, M.D.

★ Camden-Clark Memorial Hospital, April 28, 7 a.m., "ARDS, Shock Lung," Harakh Dedia, M.D.

Philippi ★ Broaddus Hospital, April 8, 7 p.m., "Sexual Counseling for the Office Practitioner," Kenneth Reamy, M.D.

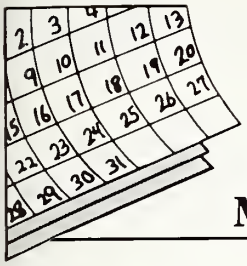
Point Pleasant ☐ Pleasant Valley Hospital, April 22, noon, "Surgical Complications of Acute MI," Rakesh Wahi, M.D.

Spencer ☐ Roane General Hospital, April 30, 12:30 p.m., TBA

White Sulphur Springs ★ Greenbrier Clinic, April 12, 4 p.m., TBA

Williamson ☐ Williamson Appalachian Regional Hospital, April 22, 5:30 p.m., "Pediatric Transport Concept," Pediatric Transport Team

"HOW DOES THE STORK MATCH UP THE CHROMOSOMES?"



Medical Meetings

March

26—Annual Spring Conference of the West Virginia Society for Autistic Children, Huntington

26-28—West Virginia Urological Society's Annual Meeting, Huntington

April

1-4—American College of Physicians, Washington, D.C.

2-3—International Conference on HDL-Cholesterol and Triglycerides Role in Coronary Heart Diseases and Laboratory Measurement, Georgetown University Medical Center and the Giovanni Lorenzini Foundation (sponsors), Washington, D.C.

8-9—Hands-on Workshop on Advanced Diagnostic Methods in Andrology, Eastern Virginia Medical School (sponsor), Norfolk, Va.

16-18—41st Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians, Morgantown

17—Minimally Invasive Therapies for Common Diseases, Georgetown University Medical Center (sponsor), Washington, D.C.

17-20—American College of Preventive Medicine, St. Louis

19-20—Infectious Diseases in Everyday Medicine — 3rd Annual Symposium, University of Maryland School of Medicine (sponsor), Baltimore

19-24—American Cleft Palate - Craniofacial Association, Pittsburgh

20-22—American Laryngological, Rhinological and Otological Society, Los Angeles

22-25—46th Annual National Spring Meeting of the West Virginia Academy of Ophthalmology, White Sulphur Springs

23-24—Obstetric and Gynecological Ultrasound in Clinical Practice: Reflections and Resolutions, Ohio State University (sponsor), Columbus

24-30—American College of Occupational and Environmental Medicine, Atlanta

25-May 1—American Academy of Neurology, New York City

25-28—American Group Practice Association, Washington, D.C.

28-May 2—Association for Hospital Medical Education, Tucson, Ariz.

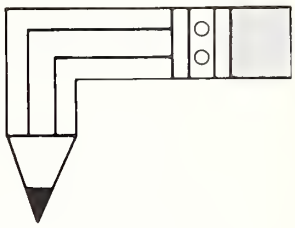
29-May 1—Annual Spring Meeting of the West Virginia Chapter of the American College of Surgeons, White Sulphur Springs

30-May 2—Pathology of HIV, George Washington University Medical Center (sponsor), Arlington, Va.

For More Information . . .

Contact the Journal at (304) 925-0342 for additional information about most of the above meetings.

Poetry Corner



Once Upon a Time

Today she looked and touched
Looked at times past
Touched old scars
She felt again the pain
There were tears
And silence

Fresh understanding of old
realities had quenched the
flicker of new hope
But there remains new love
Stronger love
Enduring love
And new dreams

Ronald C. Michels, M.D.

Sleep

Sleep is an interlude or momentary lapse
In purpose-filled and conscious thought;
But with a troubled mind, sometimes, perhaps
Much needed sleep cannot be bought;
For in a problem-filled and active brain,
The search for sleep is often fraught
With restless hours and little gain
Of the self-renewal which is sought.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Special Note: Since March is National Nutrition Month, this month's page features information to improve the nutrition of West Virginians.

Nutrition month stresses healthier eating habits

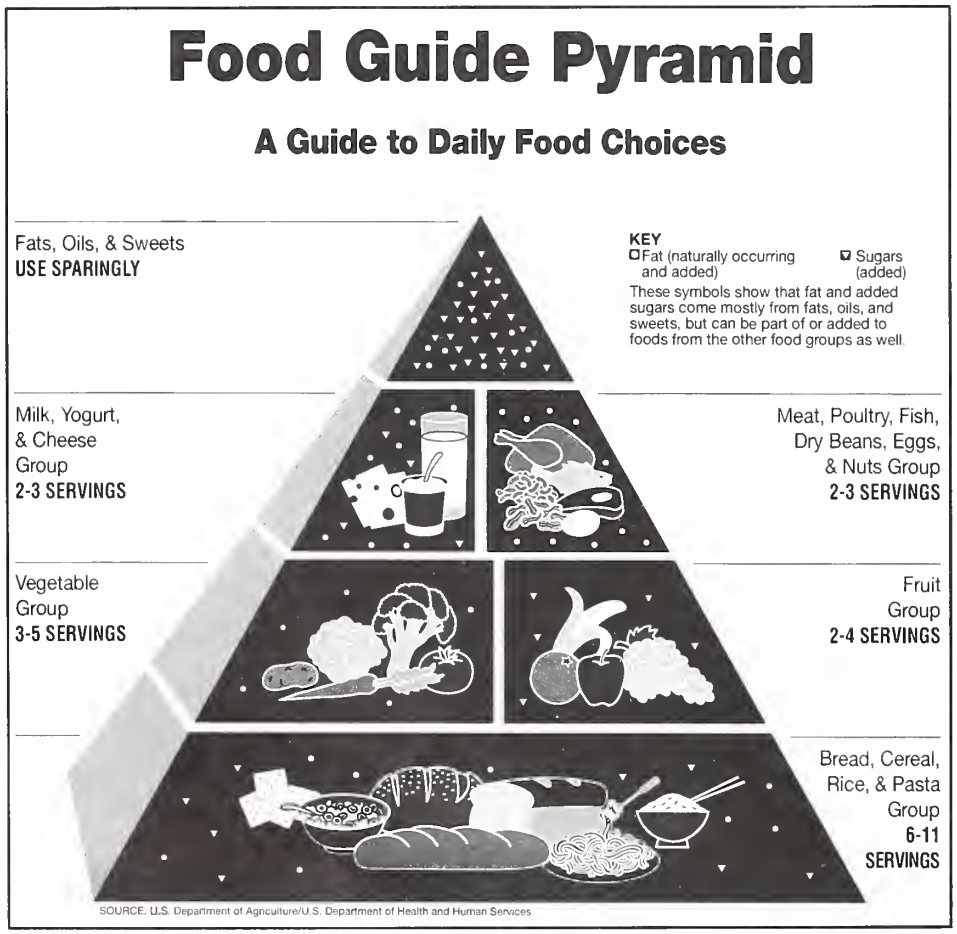
Rethink your eating habits from the ground up -- that's the message of the 1993 National Nutrition Month® EAT RIGHT AMERICA™ campaign. This year's campaign focuses on teaching West Virginians to use the U.S. Department of Agriculture's Food Guide Pyramid as a tool to promote healthier eating patterns.

During March, the Bureau of Public Health will be launching a campaign to show the public how easy it is to use the Food Guide Pyramid to build a better diet from the ground up.

"Grains, fruits and vegetables are the base of the Food Guide Pyramid for good reason," says Denise Ferris, R.D., director of the Office of Nutrition Services. "These are the food groups that form the foundation of good nutrition...yet they are also the foods that we tend to neglect in our overall diets."

According to Ferris, most Americans are unfamiliar with the recommended number of servings needed each day from the six groups in the new food guide, and are even more confused about serving sizes and amounts.

For more information about the EAT RIGHT AMERICA™ campaign and the Food Guide Pyramid, call Denise Ferris at 558-0030.



WIC program buying infant formula in bulk

Effective May 1, the West Virginia State WIC (Women, Infants, and Children) Program will join forces with four other states to improve buying power to lower the cost of infant formula. The single supplier for WIC formula is the Mead Johnson brand of milk-based, iron-fortified formula (Enfamil) and soy-based, iron-fortified formula (Prosobee). Other formulas will still be available if prescribed by a physician for infants with medical conditions.

West Virginia has had open-market supplier contracts since 1989 to receive rebates on three brands of formula. Recently, Congress mandated that all states maximize rebate savings. Bidding for a single supplier system with other states in the Mid-Atlantic Region has achieved the greatest savings for West Virginia.

The goal of maximizing savings with infant formula rebates is to serve more at-risk children. West Virginia is now only able to serve about 50% of the potentially eligible WIC population. The additional $1 million generated by the single supplier system will allow more state children to be served.

Breastfeeding promotion continues to be a focus of the WIC Program. Information on breastfeeding will be included in the educational efforts about the change to a single supplier of infant formula. All pregnant women will be encouraged to breastfeed as the optimal method of infant feeding.

If you would like more details, please call the State WIC Office at 558-0030.

WIC to offer new food package for breastfeeding mothers

Effective May 1, the West Virginia WIC Program will offer a new increased food package for WIC mothers who are exclusively breastfeeding their infants.

The enhanced food package, which adds canned tuna, fresh carrots, and extra amounts of other WIC foods, is designed to promote and reward exclusive breastfeeding.

University of Pittsburgh

University of Pittsburgh
Medical Center

University of Pittsburgh
School of Medicine

Center for
Continuing Education
in the Health Sciences

Presbyterian University
Hospital
Department of Medicine

Western Psychiatric Institute
and Clinic
Consultation-Liaison Service

STRATEGIES IN TREATING THE DIFFICULT, SOMATIZING PATIENT

FRIDAY, MAY 14, 1993

WILLIAM PITT UNION • UNIVERSITY OF PITTSBURGH
Pittsburgh, Pennsylvania

COURSE DIRECTORS: *Robert M. Arnold, M.D. • Joseph P. Klutz, M.D. Renée T. Kubacka, Pharm.D. • Jamie A. Mullen, M.D.*

Individuals with somatoform disorders are among the most challenging and resource-demanding patients for primary care practitioners. This conference will address the etiology, phenomenology, diagnosis, and management of somatoform disorders, especially hypochondriasis and somatization disorder. Background presentations will provide a solid grounding in diagnostic classification and psychosocial models of somatization, and videotaped dramatizations of patient situations will be used as starting points for small group discussions of management problems in patients with somatoform disorders. Faculty will be drawn from the medical staffs of local hospitals with family practice and internal medicine training programs and from the staff of the University of Pittsburgh Medical Center.

FOR MORE INFORMATION CONTACT:

Sheila Woodland

Telephone: (412) 647-8262
Fax: (412) 647-8222

Western Psychiatric Institute and Clinic
Division of Public Psychiatry
Mental Health Conference Planning
3811 O'Hara Street
Pittsburgh, PA 15213-2593

University of Pittsburgh

University of Pittsburgh
Medical Center

Center for
Continuing Education
in the Health Sciences

University of Pittsburgh
School of Medicine

Western Psychiatric Institute
and Clinic
Consultation-Liaison Service

FOURTH ANNUAL PITTSBURGH NEUROPSYCHIATRY CONFERENCE:

NEURAL PATHWAYS AND BEHAVIOR

With emphasis on: • *Prefrontal Cortex* • *Disconnection Syndromes* • *Cortical Inhibitory Mechanisms* • *Neural Networks*

FRIDAY, APRIL 23, 1993

HOLIDAY INN AT UNIVERSITY CENTER
Pittsburgh, Pennsylvania

COURSE DIRECTOR: *Paula Trzepacz, M.D.*

The Fourth Annual Pittsburgh Neuropsychiatry Conference will present current information on important topics in neuropsychiatry—this year on the theme of neural pathways and behavior. Speakers will include physicians from both psychiatry and neurology, and planned topics range from discussion of neural network models to cerebral disconnection. The significance of the advances being made in the field of neuropsychiatry, particularly examining the relationship between neural pathways and behavior, will be of interest to health care professionals in the fields of psychiatry, neurology, and rehabilitation.

FOR MORE INFORMATION CONTACT:

Mary McAuley

Telephone: (412) 647-8265
Fax: (412) 647-8222

Western Psychiatric Institute and Clinic
Division of Public Psychiatry
Mental Health Conference Planning
3811 O'Hara Street
Pittsburgh, PA 15213-2593

WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center, Communications Division, Morgantown.

New residency program approved

Ducatman

The School of Medicine has received accreditation for its newly established residency program in Occupational and Environmental Medicine.

This residency includes a two-year training program, with the resident receiving a master's degree in public health and the opportunity to work with engineers, state and federal officials, and others in industrial settings such as steel mills, coal mines and chemical factories. Residents will also have the opportunity to work with researchers at the National Institute for Occupational Safety and Health on the WVU Health Sciences campus.

According to Alan Ducatman, M.D., M.S.C., director of the institute, environmental and occupational health specialties are projected to experience a severe shortage of trained physicians in the future. He commented that WVU-trained residents will find great demand for their services in not only patient care, but also to serve as consultants to industry, government and labor.

Gutmann receives honorary degree

Gutmann

Dr. Ludwig Gutmann, professor and chair of neurology, has received an honorary doctor of medicine degree from the University of Mainz in Germany in recognition of his international reputation as a neurologist and researcher in the area of neuromuscular diseases.

During the last 10 years, Dr. Gutmann has made annual visits to the University of Mainz where he has participated in several research studies, including studies dealing with organophosphate poisoning of humans. During that time, Dr. Gutmann helped neurology faculty members at the University of Mainz develop collaborations in the United States. He also provided educational opportunities for the school's medical students at WVU.

Dr. Gutmann received the honorary degree at an academic festival held in his honor January 20 in Mainz. At the festival, he discussed "The Education of the American Physician."

Grant to support community cancer prevention projects

A five-year, $1 million project to support the development of community-based cancer prevention and control projects in West Virginia and Ohio will be based at the Mary Babb Randolph Cancer Center.

This program, the Appalachian Leadership Initiative on Cancer (ALIC), will support cancer activities in all 55 West Virginia counties and the 29 Appalachian counties of Ohio. Riverside Regional Cancer Institute in Columbus will coordinate ALIC activities in Ohio.

The National Cancer Institute, which is funding the project, created ALIC to respond to recent data that indicates higher incidences of certain cancers in Appalachia, as well as increased rates of mortalities from these diseases. The data also suggests that tobacco use and other behavioral causes of cancer are higher in the region.

According to Fred R. Butcher, Ph.D., director of the Cancer Center and principal investigator for the project, the community efforts will involve the entire population, but they are targeted to minorities, low-income families and individuals, people with poor reading skills, and individuals with limited access to health care.

Other universities participating in the ALIC are Penn State, for Appalachian areas of Pennsylvania, New York and Maryland; the University of Kentucky, for Kentucky, Tennessee and Virginia; and North Carolina State, for North and South Carolina and Georgia.

APA medical student education award presented to Fidler

Fidler

Dr. Donald Fidler, associate professor of behavioral medicine and psychiatry, is the recipient of the third annual Nancy C.A. Roeske, M.D. Certificate of Recognition for Excellence in Medical Student Education.

This certificate, awarded by the American Psychiatric Association and its Committee on Medical Student Education, recognizes outstanding and sustaining contributions in medical student education.

Surgery competition winners announced

Dr. Steven Bossinger, a second-year resident in the Department of Surgery, won first place in the Department's annual Junior Resident Presentation competition with his presentation "The Role of Computed Tomography in the Diagnosis of Acute Appendicitis."

Drs. Houman Khosrovi and Joy Steadman, first-year residents, tied for second place. Dr. Khosrovi's topic was "The Development of Carotid Artery Disease in Patients Who Have Had a Coronary Artery Bypass Graft;" and Dr. Steadman discussed "The Incidence of Wound Complications in Female CABG Patients Who Have Had a Prior Mastectomy."

The third place award went to Dr. Robert Owens, a first-year resident for "Complications Related to Silicone Breast Implants — the WVUH Experience."

Where quality is affordable . . .

Participating Dealer For AMERINET, SUNHEALTH, and VHA ACCESS

BEAUTIFUL OFFICE SUITES in easy to visualize arrangements featuring styles in TRADITIONAL, CONTEMPORARY, PERIOD and more. Enjoy the beauty of CHERRY, OAK, MAHOGANY and WALNUT. You'll find them all on our showroom floors.

CUSTOM OFFICE FURNITURE, INC.

1260 GREENBRIER ST. CHARLESTON, WV 25311

INTERIOR DESIGN SERVICE
SPACE PLANNING

PHONE 343-0103 or 1-800-734-2045
WV CONTRACTOR NO. WV008652

Perioperative Transfusion Medicine

May 14-15, 1993

WVU Health Sciences Center
Morgantown, West Virginia

Topics include:

- Update on Transfusion-Transmitted Infections
- Preoperative Autologous Blood Donation
- Perioperative Autologous Blood Salvage
- Preoperative Evaluation of Hemostasis
- The Transfusion Trigger for Perioperative Red Blood Cell Transfusion
- Leukocyte Depletion of Cellular Blood Components in Perioperative Hemotherapy
- Pharmacologic Adjuncts to Perioperative Hemotherapy

To register, contact: The Office of CME at 1-800-WVA-MARS or 304-293-3937

Sponsored by: WVU School of Medicine Office of Continuing Medical Education, WVU Department of Pathology, and the Johnstown Region - American Red Cross Blood Services

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

MU obtains state-of-the-art electron microscope

Dr. Ruu-Tong Wang prepares to examine a specimen with Marshall University's powerful new electron microscope.

A new electron microscope is transporting Marshall University medical researchers into a world so tiny that a baseball bat would stretch from Huntington to Martinsburg and a body cell would loom larger than a huge living room.

Dr. Ruu-Tong Wang, an associate professor of anatomy and cell biology, received the $180,000 grant for the microscope, which he said is one of the most sophisticated in the nation. It is so advanced, that Marshall researchers must promise the U.S. government they will not leak information about its technology to certain restricted nations.

"This is a dream come true for the Medical School," said Dr. Wang. "It gives us capabilities that rank among the top schools in the country."

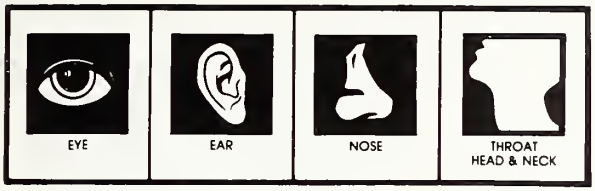
The microscope was purchased through an "extremely competitive" grant program of the National Institutes of Health, according to Dr. William B. Rhoten, chairman of the Department of Anatomy and Cell Biology. He predicted that in addition to its immediate applications in biomedical research and education, the microscope will help support technological and economic development in the region.

This new device gives researchers a much more complete picture of a sample, Dr. Wang said. It can both look inside a cell or at its surface, and also has a powerful computer program to gather, interpret and display data. According to Hitachi, the company which manufactured the microscope, there are fewer than 80 of its type available in the United States.

"Thanks to the generosity of INCO Alloys and the VA Medical Center, Marshall researchers have had basic models of electron microscopes available for many years," Dr. Wang said. "Now, with the help of the National Institutes of Health and the Hitachi Company, which gave us a major educational discount, we have the newer technology necessary to work at the molecular biology level."

Dr. Wang will use the microscope in his research concerning the development of the nervous system and the following faculty members will also be utilizing it:

- Dr. Terry Fenger will investigate HIV pseudo-particles;
- Dr. Ernest Walker will examine ways lead poisoning affects the nervous system;
- Dr. Sasha Zill will explore sense organs which insects use in movement;
- Dr. Michael Moore will study progestin stimulation of growth in human breast cancer cells;
- Dr. Gary Wright and Dr. William McCumbee will investigate how a hypertensive factor works and how diet affects it;
- Dr. Gary Rankin will examine chemically-induced nephrotoxicity;
- Dr. John Szarek will mechanisms of oxygen-induced airway hyperresponsiveness;
- Dr. Carl Gruetter will investigate the role of endothelium in pulmonary vasoreactivity;
- Dr. Richard Niles will study differentiation of trachea cells; and
- Dr. Mark Simmons will study mechanisms of synaptic modulation in sympathetic neurons.



EENT Seminar for Primary Care Physicians 1993 Update

Topics Include:
Sinusitis
Ophthalmic Emergencies
Common Pediatric EENT Conditions

DATE
Saturday, May 22, 1993

LOCATION
Charleston Marriott

CREDIT
4.5 Hours AAFP
4.5 Hours CME Credit, Category I

SPONSOR
The Eye and Ear Clinic of Charleston, Inc.

CO-SPONSOR
Department of Family Medicine
WVU Health Sciences Center
Charleston Division

For Registration Information, Call:
353-0324
Toll-Free in WV:
1-800-642-3049, ext. 324

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

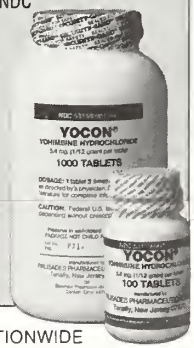
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Domestic violence bill deserves serious attention

It amazes me that a few gentlemen journalists around this state have nothing better to do than make fun of a piece of legislation that should have no consequence to them.

The legislation, **HB 2024,** would require a statement on an application for a marriage license that each spouse should be free from violence and abuse. The statement would also include the penalties involved for an act of violence. Recently, two male newspaper journalists have made fun of this legislation and obviously feel it is a waste of time. Why even radio talk-show host Rush Limbaugh made a statement that the idea was as useless as placing a warning label on cigarettes -- it's there but no one reads it.

This legislation, which I take full responsibility for since it was my idea, was introduced by two respected delegates, Robert Kiss (D-Raleigh) and L. Gil White (R-Ohio), and in my opinion is by no means useless. Consider for a moment these depressing statistics. **DOMESTIC VIOLENCE** is the leading cause of injury to women ages 15-44; violence will occur at least once in two-thirds of all marriages; there were 3,040 reported domestic violence cases in our state in 1990, and by 1991 there were 4,623 cases reported, a 52% increase.

These statistics speak for themselves, but in addition, one must consider the high medical costs that go into treating victims of abuse. That cost is usually generated in the emergency room -- one of the most expensive areas in health care.

Useless -- this legislation is only useless for those closed-minded individuals who refuse to see that victims of abuse may be a fellow employee, may live in their neighborhood, or may even be a relative.

No, a statement explaining the laws against domestic violence may not solve this depressing and demoralizing problem, it may not even come close. But this legislation has no fiscal note attached to it. The cost, if anything, would be minimal.

The goal of the West Virginia State Medical Association Auxiliary, as well as the Domestic Violence Coalition and other groups involved with this issue is **AWARENESS**. If our bill makes one person aware that there is help and that there are laws to protect them, then our goal has been achieved!

Pacita Salon
WVSMAA President

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH

EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD

Specializing in
Head and Neck Cancer Surgery
Cosmetic Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

- **35-bed JCAHO Accredited Hospital**
- **Ambulatory Care/ Same Day Surgery**

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)

West Virginia Chapter

American College of Surgeons

Annual Spring Meeting **April 29 - May 1, 1993**

The Greenbrier - White Sulphur Springs, West Virginia - 10 Hours CME

Guest Speakers:

Louis Del Guercio, M.D.
Professor and Chairman, Surgery
New York Medical College

Eddie Joe Reddick, M.D.
Nashville, Tenn.

R. Phillip Burns, M.D.
Professor and Chairman, Surgery
Chattanooga Unit-University of Tenn.

Other Statewide Speakers, Including the Annual Residents' Competition-Saturday, Tennis Tournament-Thursday, Golf Tournament-Friday.

Registration: WV Chapter American College of Surgeons
P.O. Box 1107
Morgantown, WV 26505

Rooms: (304) 536-1110

New Members

We want to welcome the following new members to the WVSMA:

Donald L. Hoffman, M.D.
Ruby Memorial Hospital
Morgantown, WV 26505

Abdel F. Massoud, M.D.
Chestnut Ridge Hospital
Morgantown, WV 26506

Roger Riley, M.D.
WVU School of Medicine
Morgantown, WV 26506

Kathleen Rosen, M.D.
WVU Health Sciences Center
Morgantown, WV 26506

Michelle Irvin, M.D.
800 Garfield Avenue
Parkersburg, WV 26101

Sandra Elliott, M.D.
3100 MacCorkle Avenue SE
Charleston, WV 25304

Rakesh Wahi, M.D.
3100 MacCorkle Avenue SE #209
Charleston, WV 25304

Ilene R. Blacksberg, M.D.
Fairmont Clinic
Fairmont, WV 26551-1112

Imad Shureiqi, M.D.
Fairmont Clinic
Fairmont, WV 26551-1112

Seema Rao, M.D.
Fairmont Clinic
Fairmont, WV 26551-1112

Juan Reyes, M.D.
Fairmont Clinic
Fairmont, WV 26551-1112

Elaine M. Young, M.D.
1652 14th Avenue
Huntington, WV 25701

Thomas Karrs, M.D.
P.O. Box 1104
Lewisburg, WV 24901

Verna Hanes, M.D.
P.O. Box 1104
Lewisburg, WV 24901

Kevin Woissard, M.D.
1115 20th Street
Huntington, WV 25703

County Societies

Greenbrier Valley

At their January meeting, members elected the new officers for 1993.

Kyle Fort, M.D., F.A.C.S., was elected president; Alan Lee, D.O., was named vice president; and Stephan Thilen, M.D., was elected secretary/treasurer.

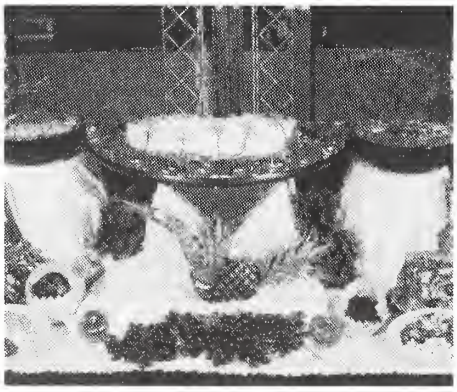
Monongalia

Gregory Timberlake, M.D., was the featured speaker for February meeting. He discussed his experiences while serving in Project Desert Storm.

Dr. Pearson presented Drs. Robert G. Pretorious, Angel O. Ortiz, and Vincent W. DeLarza for membership via first reading. In addition, he also presented Drs. Walter Taubenslag, Ronald S. Wargacki, Jerry M. Traver and Karen C. Gerbo for membership via second reading. All of these physicians were approved.

Drs. Stead, Sebert and Ryan spoke briefly about the proceedings at the WVSMA's Mid-Winter Clinical Conference, and Dr. Sebert stressed the importance of establishing and maintaining a close relationship with members of the Legislature.

Radisson's Renaissance



CHARMING – COMFORTABLE – CASUAL

The restaurant of choice for all dining occasions or no occasion at all – just for the food! Have a simple breakfast, lunch or dinner anytime. For those days when you're really hungry or want to impress yourself or someone else try –

- Spectacular Sunday Brunch
- Fabulous Friday Night Seafood Buffet
- Wednesday Night Unlimited Prime Rib Buffet
- Smokehouse Saturday Night

Radisson Hotel Huntington
1001 Third Ave., Huntington, WV • 304-525-1001

Obituaries

Emma Jane Freeman, M.D.

Emma Jane Freeman, M.D., 69, of Buckhannon, died on February 6 at the home of her sister, Pauline Hodgkiss.

Born in Adrian, W.Va., Dr. Freeman received A.B. and B.S. degrees from West Virginia University, where she also attended two years of medical school before transferring to the Medical College of Virginia in 1949. She received her medical degree from the Medical College of Virginia in 1951 and then completed her internship and a two-year residency in pediatrics at the college.

Dr. Freeman obtained her West Virginia medical license in 1954 and located in Buckhannon to practice pediatrics. She remained in Buckhannon until 1960, when she became director of the Division of Maternal and Child Health in the West Virginia Health Department. Dr. Freeman held this post for a year and then relocated to Bridgeport to return to private practice.

In 1974, Dr. Freeman accepted a position as an emergency room physician at United Hospital Center in Clarksburg. After nearly 10 years at United, she returned to Buckhannon to practice at Leonard Memorial Hospital, where she retired in 1988.

A WVSMA member since 1955, Dr. Freeman was also a member of the AMA, the Harrison County Medical Society and the Aletha Chapter 82, Order of the Eastern Star.

Dr. Freeman is survived by one brother, Brent H. Freeman of Adrian; two sisters, Jo-Anne Rill of Memphis, Tenn., and Pauline F. Hodgkiss of Buckhannon; and one niece and four nephews.

L. R. Leeson, M.D.

L. R. Leeson, M.D., 84, of Parkersburg, died in January 25 at his residence after an extended illness.

Dr. Leeson was born in Ravenswood, W.Va., and received A.B. and B. S. degrees from West Virginia University. He earned his medical degree at Rush Medical College in Chicago in 1935, and then completed an internship at the Evangelical Hospital of Chicago and a residency at Passavant Memorial Hospital.

Following his postgraduate studies, Dr. Leeson began his private practice in Thacker in 1938 and then moved to Parkersburg, where he established an office briefly until he joined the E. I. duPont Company in Morgantown as a company physician. He later returned to Parkersburg and re-established his private practice before entering the U.S. Army in 1942. Dr. Leeson earned the rank of first lieutenant and was stationed as a physician-surgeon at Presidio in San Francisco.

Following his military service, Dr. Leeson moved back to Parkersburg and re-opened his medical practice, which he continued until his retirement in 1984. During his career, Dr. Leeson was a physician at St. Joseph's Hospital and Camden-Clark Memorial Hospital. He had been a member of the WVSMA since 1942 and was also a member of the Parkersburg Academy of Medicine.

Dr. Leeson is survived by his wife of 54 years, Mary E. Wilcox Leeson; one son, Larry G. Leeson of Maineville, Ohio; one brother, Gordon L. Leeson of San Diego; two grandchildren; and three great-grandchildren.

Revenue Optimization

What is Revenue Optimization?
Revenue Optimization addresses the fundamentals which govern your gross revenue and, therefore, your net income.

FEE ANALYSIS
- Your fees are converted to a relative value basis using the Systemetrics-McGraw/Hill relative value system.

CODING/REIMBURSEMENT ANALYSIS
- We analyze and evaluate your procedure code usage (and non-usage), including levels of service for the office, hospital, consultation and ER/Outpatient service as well as your use of modifiers.
- We review your insurance claim forms and your EOBs to find ways to maximize your reimbursements, minimize reductions and denials, and minimize the chance of audit.

MEDICARE/RBRVS
- The primary function is to protect your revenue under both par and non-par status, enabling you to make a rational and objective decision about your participation status with Medicare.
- In the process, we calculate your Medicare allowed amount and the co-payment amount for every procedure under both par and non-par status. RBRVS Analysis is included, showing you the effect of RBRVS on each code you use and on all codes collectively.

ON-SITE CODING/ REIMBURSEMENT
- If your personnel needs hands-on help, we come to you. We "audit" your complete reimbursement system including: procedure coding, diagnosis coding, charges, claims filing, reimbursements, and chart documentation. If needed, we will provide classroom and hands-on training for individuals or your entire staff.

YOUR SATISFACTION IS GUARANTEED
- If we do not help or if you are not satisfied with the results of your analysis — your money will be refunded!

America's Premier Consulting Firm Advising Physicians Throughout Our Nation Since 1956

RCFA Physician Managers Inc.

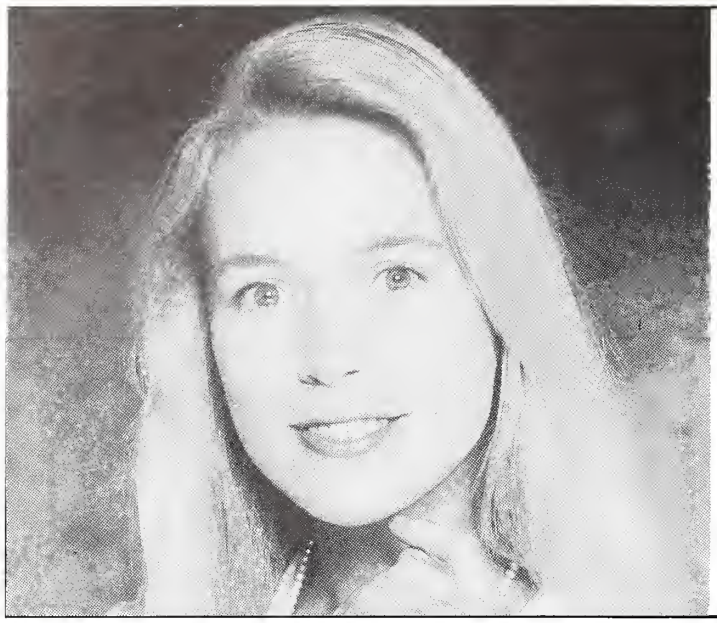
9724 Kingston Pike, Suite 1200
P.O. Box 23590
Knoxville, TN 37933-1590

Professional Practice Planners

332 Fifth Avenue • Suite 213
McKeesport, Pennsylvania 15132

Call Stan Pollock,
DMD, CFP, PHD, CPBC, CBA

(412) 673-3144 • 1-800-635-4040



Now there's a safer and more effective treatment for red vascular birthmarks

Fast . . . F.D.A. Approved . . . and near your hometown.

With our new Candela Vascular Lesion Laser, we can now treat birthmarks like Port Wine Stains and other red blemishes including small facial veins . . . effectively and with minimum discomfort.

Call for a consultation appointment:

1-800-628-6748

LAWRENCE W. TARRANT, M.D.

Certified By: American College of Surgeons
American Board of Plastic Surgery
Fellow of the American College of Surgeons
Fellow of the Royal College of Surgeons (Canada)

THE MYERS CLINIC — Philippi, West Virginia

Notice: Seeking Internal Medicine, Pediatrics, and/or Family Practice, must be Board Certified or Board Eligible.

Also: Seeking Locum Tenen—Family Practice

Contact: Lonnie L. Crane, 112 North Woods Street, Philippi, WV 26416. 1-(304) 457-2800

Radiology:
Halberto G. Cruz, M. D.

Pathology:
Fulvio Franyutti, M. D.

Surgery:
J. W. Woodford, M. D.

Pediatrics:
E. G. Kreider, M. D.

Internal Medicine:
Karl J. Myers, Jr., M. D.
Z. Moussa, M. D.

WMC Inc.

WILLIAM C MORGAN, Jr., M.D., F.A.C.S.
Otologist
Diplomate, American Board of Otolaryngology

OTOLOGY: DISEASES & SURGERY OF THE EAR

Sheri L. Jeffries
Audiologist

304-345-7100

Complete Audiological Services • Hearing Aid Dispensing & Service
Assistive Listening Devices • Electronystagmography • ABR

ST. FRANCIS MEDICAL PLAZA • 331 LAIDLEY STREET, SUITE 602 • CHARLESTON, WV 25301

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA
MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article

Kanawha County launches mini-internship program 142

Scientific Newsfront

Radiofrequency catheter ablation for recurrent ventricular tachycardia
Ronald McCowan, M.D. 144

Choroidal metastasis from primary mucinous cystadenocarcinoma of the ovary
Curtis D. White, M.D.; Warren L. Cooper, M.D.; Rodney R. Williams, M.D.; and Albert B. C. Flemming, M.D. 146

New Manuscript Guidelines 147

Therapy for congestive heart failure in the late 20th century (Medical Grand Rounds from West Virginia University Health Sciences Center, Edited by Irma H. Ullrich, M.D.)
L. Phillips Maxwell, M.D.
Abnash Jain, M.D. (Discussants) 148

President's Page

We - Them, Sunshine and the Orange and Black 154

Editorial

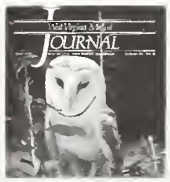
Congressional need 155

Our Readers Speak

A different perspective on obstetrical data 156

Special Departments

General News 160
Continuing Medical Education 164
Medical Meetings/Poetry Corner 165
Bureau of Public Health News 166
WVU Health Sciences Center News 168
MU School of Medicine News 170
Medical Student News 172
Obituary/County Societies 174
Classified 177
April Advertisers 178

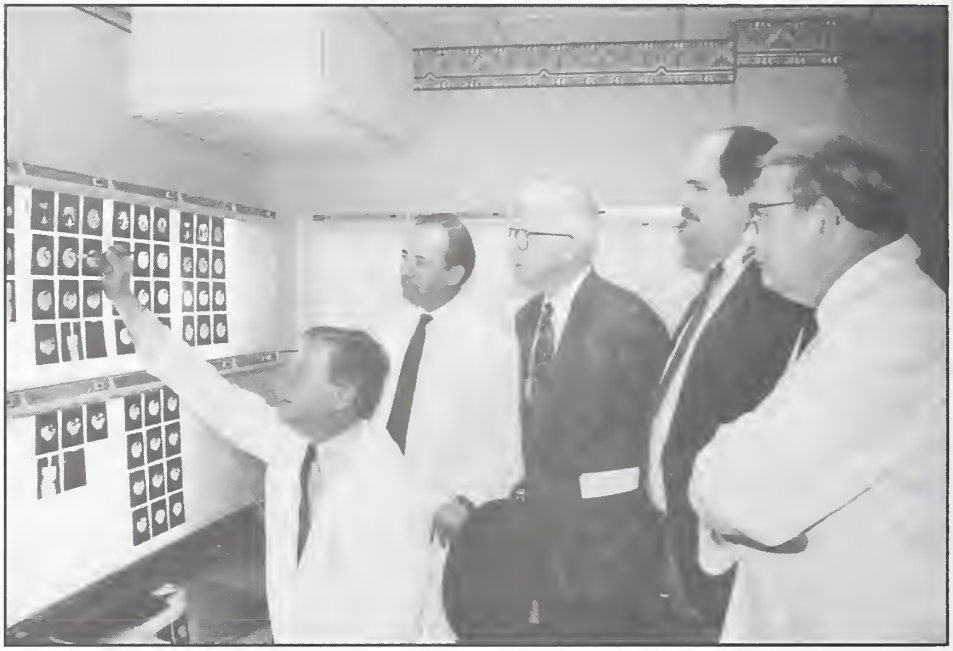


Front Cover

A barn owl perches on a stump on the grounds of the Three Rivers Raptor Rehabilitation Center near Hinton in Summers County. Photo courtesy of *David Fattaleh,* West Virginia Division of Tourism and Parks.

Kanawha County launches mini-internship program

PEIA Director Sally Richardson watches intently as Dr. Tom Sporck creates a new eardrum for a teenage patient at the One Day Surgery Center at St. Francis Hospital.



At Thomas Memorial Hospital, Dr. Tom Hayes shows CT scans to interns Tim Sharp, news director of WCHS-TV (second from left), and Senator Robert Holliday (right). Pictured with them are Dr. George Hogshead, Thomas Memorial's medical director, and Dr. Michael Hall.

The Kanawha County Medical Society teamed up with the WVSMA in February to provide 11 community leaders with a "first-hand look" at medical care today through a new mini-internship program.

The first program of its kind to be implemented in West Virginia, this mini-internship gave people from government, private industry, the media, and membership associations the chance to interact individually with four physicians who represent different medical specialities. For two days, the interns spent a half a day each with "their" four physicians, so they could observe their daily routines and ask questions.

Following the two-day program, a debriefing dinner was held at The University of Charleston so the 11 interns and 37 physicians who participated could discuss their experiences. At the dinner, all of the interns described the insights they had gained from the program.

"I knew doctors were intelligent and skilled, but the compassion and empathy they showed toward their patients is what impressed me," said Karen Wright Readshaw, benefits director for the Union Carbide Corporation. "All of us, business, industry, government and the medical community need to work together to solve the health care problem."

Delegate Joe F. Smith (D-Kanawha) spent part of his internship in the emergency room at Thomas Memorial Hospital and was amazed at how many of the patients came in with questionable "emergencies."

"The value of the emergency room is being jeopardized by people making unnecessary visits who should be seeking attention from family physicians," Smith commented. "Is the system being unnecessarily overloaded by people who need to care for themselves in a more mature fashion or manner? Whenever 'someone else pays for it,' I wonder if people really are concerned about the cost," he added.

PEIA Director Sally Richardson, who recently was assigned to Hillary Rodham Clinton's Health Care Task Force, also served as an intern. "I appreciated the comprehensive program which gave me a lot of different looks at the medical profession in just two days," she said. "I was impressed by the teamwork in the operating room and the compassion and patience shown toward patients."

Another intern, Patrick Bond, benefits director for One Valley Bank, felt that the program was a "tremendous experience which needs to be expanded. Public relations is critical for the medical profession to open up and tell their stories to the public."

The Charleston physicians who volunteered their time to this first mini-internship said the program was very beneficial in fostering the public's understanding of medicine's

inner workings. Many of the physicians said they felt the interns gained insights into their relationships with patients, as well as observed how factors such as third-party payors, insurance billing, and government regulations are affecting the practice of medicine. In addition, the physicians valued the opportunity to interact with the interns because they offered such varying perspectives.

"All of us, business, industry, government and the medical community need to work together to solve the health care problem."

Based on the success of their first program, the Kanawha County Medical Society plans to continue offering this program twice a year, and the next mini-internship is planned for the fall. Since it has proven to be a valuable tool in opening communications channels between physicians and the community, the WVSMA is encouraging all other county medical societies to consider starting a mini-internship.

If you are interested in being considered as an intern or physician in Kanawha County's mini-internship or your county medical society is interested in implementing one of these programs, please contact Michelle Ellison, public relations manager of the WVSMA, at (304) 925-0342.

(Top) Dr. David Ritchie and intern John Bowyer, director of human resources for the Charleston Newspapers, listen as patient James Maguire tells a humorous anecdote during his checkup. (Center) David Brown, Ph.D., director of the Office of Aging, reviews some publications with Dr. Michael Lewis, associate vice president for health sciences at WVU's Charleston Division, and Dr. Joe Skaggs, medical director for CAMC, during his internship. (Bottom) At the debriefing dinner, Harold Nickell, a representative for the AARP, describes his experiences during the mini-internship and the insights he gained from the program.

Radiofrequency catheter ablation for recurrent ventricular tachycardia

RONALD McCOWAN, M.D.,
Department of Cardiology, Charleston Area Medical Center, Charleston

Abstract

Since 1989, six patients have presented to the Charleston Area Medical Center (CAMC) with ventricular tachycardia and no underlying structural heart disease. Three patients were managed with antiarrhythmic medications, and three others underwent a successful catheter ablation procedure. This article describes the case of one of these three patients who underwent catheter ablation.

Introduction

Ventricular tachycardia (VT) most often occurs in patients having coronary artery disease with the history of a myocardial infarction. When there exists a significant risk of sudden death or there are symptoms associated with the tachycardia in these patients, electrophysiology-guided antiarrhythmic drug therapy may be indicated. More aggressive management may include implantation of antitachycardia devices, arrhythmia surgery, and, rarely, catheter ablation.

The occurrence of VT in the absence of structural heart disease is much less common; however, the true incidence is unknown. Most of these tachycardias originate from the right ventricle (RV), although the left ventricle (LV) may also be the site of origin (1). The risk of sudden death in this setting is extremely low; however, patients may experience chest pain, dyspnea, dizziness, or syncope during episodes of VT.

Since 1989, six patients have presented to the Charleston Area Medical Center (CAMC) with ventricular tachycardia and no underlying structural heart disease. Three patients were managed with antiarrhythmic medications, and three others underwent a successful catheter ablation procedure. This article describes the case of one of these three patients who underwent catheter ablation.

Case report

A 51-year-old female was referred to CAMC for evaluation of a recurrent wide QRS tachycardia associated with weakness and near syncope.

The initial episode occurred two months prior to her referral and was treated by cardioversion. She was given verapamil, but the arrhythmia recurred one month later and was again managed by cardioversion. Oral sustained release procainamide, 750 mgs. every six hours, was started; however, the arrhythmia recurred one week later which prompted her referral to CAMC.

There was no history of angina, myocardial infarction, or structural heart disease. There was a remote history of hypothyroidism. She was, however, euthyroid clinically and chemically. An echocardiogram showed no structural heart disease and thallium exercise stress testing revealed no fixed or reversible perfusion abnormalities, nor did this test precipitate an arrhythmia.

Electrophysiologic testing revealed a ventricular tachycardia having a left-bundle branch block pattern with an inferior QRS axis (Figure 1). Catheter mapping of the left and right ventricles was then carried out during the tachycardia. Mapping of the LV revealed conduction times occurring later than those noted during mapping of the RV. Catheter mapping of the RV (Figure 2) revealed the earliest activation to occur at the anterior superior region of the RV outflow tract. Further confirmation that this was the site of origin of the VT was obtained by pacing of the RV at this site during sinus rhythm. The result was a re-creation of the same electrocardiographic pattern as that noted during the induced and clinical VT, which proved this to be the focus of origin of the tachycardia (Figure 3).

The patient was sedated with midazalam and given a total of three radiofrequency (RF) energy applications of 30 watts for 20-30 seconds to this region using an RF

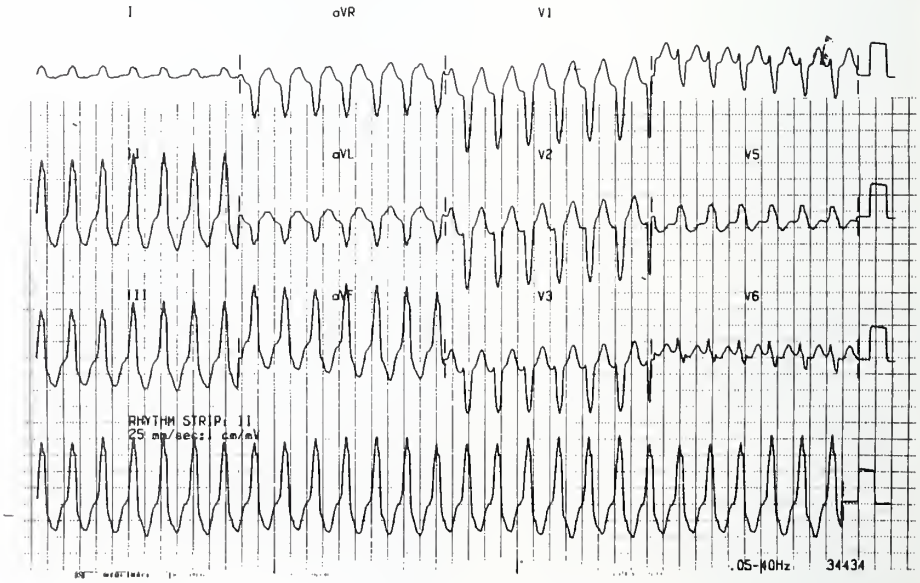


Figure 1. Induced VT having same morphology as clinical VT.

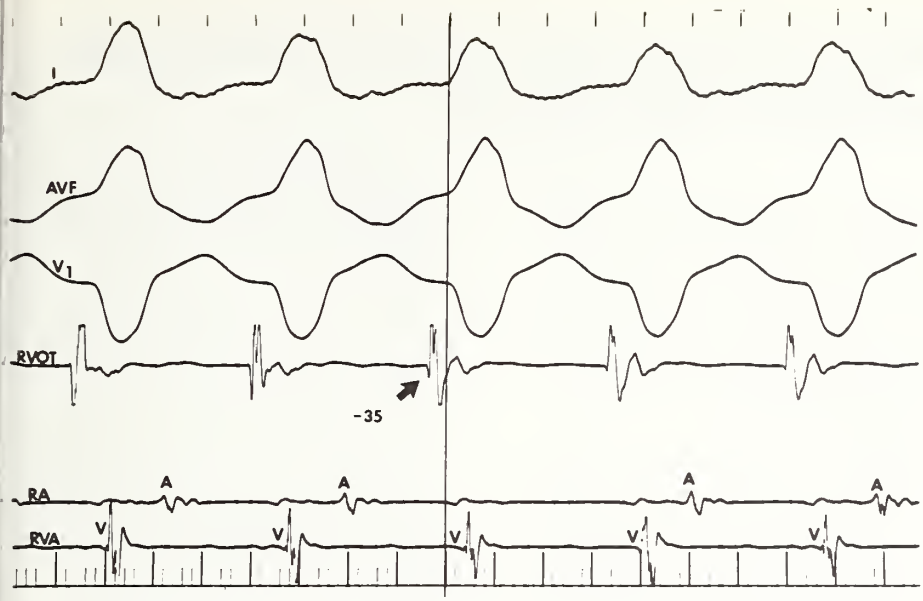


Figure 2. Catheter mapping of right ventricle during VT revealed earliest activation (-35 millisecond).

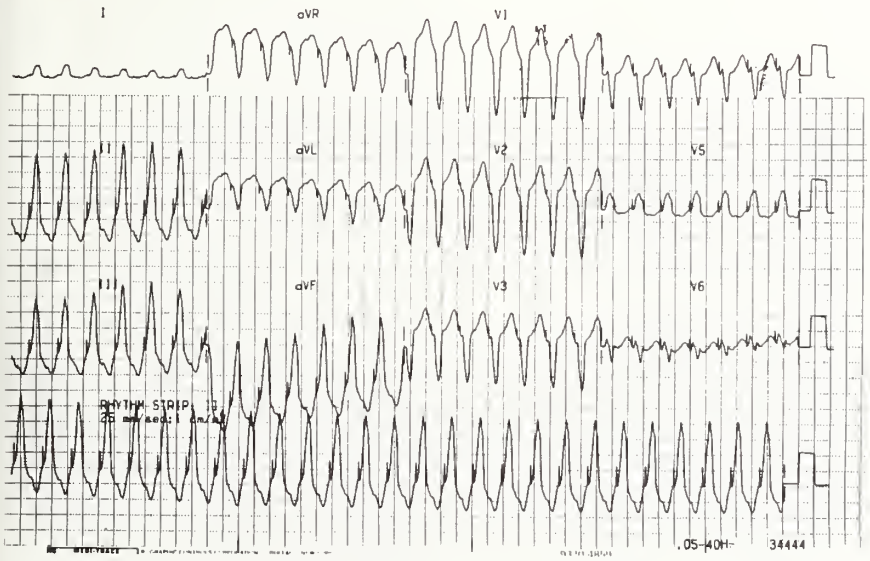


Figure 3. Pacing at the RVOT during sinus rhythm revealed the exact morphology as the patients induced VT. This was proof that the VT originated from the RVOT.

current generator. The RF current was delivered through the mapping catheter. The tachycardia was subsequently not inducible even in the presence of an isoproterenol infusion.

The patient was discharged from the hospital 36 hours later with no antiarrhythmic medications. There has been no recurrence of the VT in the last 10 months.

Discussion

Right ventricular tachycardias in adults may occur with right ventricular dysplasia and after ventriculotomy for repair of a congential heart defect, or it may be idiopathic. The patient discussed in this article had idiopathic VT (absence of structural heart disease).

Idiopathic VT may resolve spontaneously, and has a good long-term prognosis. It may occur in response to a variety of stimuli including exercise, emotional upset, changes in posture, pregnancy, and tobacco or alcohol use. The tachycardia usually has a complete left-bundle branch block morphology with a rightward QRS axis (usually not responsive to verapamil). However, it may have a complete right-bundle branch block morphology with a variable QRS axis (usually responsive to verapamil).

The use of radiofrequency catheter ablation to treat VT has been reported (2). However, its primary use has been in the management of SVT where it has afforded more than 90 percent of these patients a non-surgical cure with elimination of the need for antiarrhythmic medications.

References

1. Hoch DH, Rosenfeld LE. Tachycardias of right ventricular origin. In: Cardiology Clinics 1992;10:151-64.
2. Klein LS, Shih HT, Hacheil FK, et al. Radiofrequency catheter ablation of ventricular tachycardia in patients without structural heart disease. Circulation 1992;85:1666-74.

Choroidal metastasis from primary mucinous cystadenocarcinoma of the ovary

CURTIS D. WHITE, M.D.
WARREN L. COOPER, M.D.
RODNEY R. WILLIAMS, M.D.
ALBERT B.C. FLEMMING, M.D.
Department of Obstetrics and Gynecology, Marietta Memorial Hospital, Marietta, Ohio

Abstract

Central nervous system metastases are uncommon in epithelial carcinoma of the ovary; and metastases to the eye are even more rare. This article describes what is believed to be only the third case reported of epithelial carcinoma of the ovary metastatic to the eye.

Introduction

Ovarian carcinoma is currently the leading cause of death from gynecologic malignancies in the United States, with estimates of over 20,000 women developing this disease in 1991 (1). Due to the lack of effective screening methods and early diagnosis, the majority will have an advanced case of the disease with spread beyond the ovary at the time of diagnosis (2). In most patients, the bulk of the disease remains confined to the peritoneal cavity and forms the basis for much of current treatment regimes; but with improved local control, the appearance of distant metastases appears to be increasing.

Central nervous system metastases are still uncommon and metastases to the eye are even more rare. In the following case study, we describe the third known case of epithelial carcinoma metastatic to the choroid and the only reported case of a mucinous carcinoma cell type metastatic to this site.

Case report

A 78-year-old white female was admitted to Marietta Memorial Hospital on January 10, 1991, with the diagnosis of left femoral thrombophlebitis. She was anticoagulated and subsequently developed vaginal bleeding. Gynecologic evaluation revealed a friable mass eroding through the cul-de-sac and a large lower abdominal/pelvic mass. No cervix could be appreciated. The history was unclear as to whether the patient had ever had a hysterectomy and biopsy of the friable vaginal cuff lesion was read out as adenocarcinoma.

Subsequent laparotomy revealed a 19 cm. x 13 cm. solid and cystic mass appearing to originate from the right ovary. Its surface was free of papillary projections and the irregular mass was intact with the exception of tumor erosion through the vaginal cuff. The left ovary appeared absent. Peritoneal washings and the omentum were negative. The remainder of the peritoneal cavity appeared free of disease and cystoscopy and sigmoidoscopy were also negative. Final pathology review revealed a mucinous cystadenocarcinoma of ovarian origin, Surgical Stage II B. Flow cytometry revealed normal DNA content (DNA diploid) but an S-phase of 31.3%. Her initial CA-125 was 1074.3 U/ml.

She was started on carboplatin and Cytoxan and after two courses her CA-125 dropped to 12.3 U/ml. After six courses of chemotherapy, a chest X-ray and abdominal CT were reported as normal. She received her ninth course of chemotherapy on December 10, 1991.

In January 1992, her CA-125 increased to 300 U/ml and she noted a decrease in the vision in her right eye. An ophthalmologic evaluation revealed retinal detachment due to metastatic tumor. An ultrasound and fundoscopy by a second ophthalmologist confirmed the diagnosis of retinal detachment due to choroidal metastates. The lesion began in the ora serrata and extended all the way posteriorly. There was almost no pupillary reflex and only vague light perception.

The patient underwent radiation therapy, receiving 3,000 cGy to the right orbit from January 14 - February 7 and was begun on Alkeran. The CA-125 dropped to 138 U/ml by June of that year. She has since developed evidence of recurrent intraperitoneal disease and was admitted in September 1992, with a partial small bowel obstruction, which responded to conservative management. She remains alive with evidence of recurrent disease.

Discussion

Central nervous system metastases were once felt to be uncommon (3). In 1966, 86 autopsies of patients with ovarian cancer were reviewed by Bergman and he noted a 1.2% incidence of brain metastases (4). In addition, a review of 4,456 patients with ovarian cancer from the M.D. Anderson Cancer Center revealed that only 0.29% had central nervous system metastases (5).

Two previous cases of epithelial ovarian carcinoma metastatic to the eye have been reported; one Stage III C and one Stage IV (3,6). Both were serous cystadenocarcinomas. Our case differs in that it was a mucinous cystadenocarcinoma with an earlier-staged lesion. Though a diploid cell population, the increased S-phase of 31.3% may account for its aggressiveness.

Treatment of ovarian carcinoma usually involves aggressive treatment of the peritoneal cavity with surgical debulking followed by systemic chemotherapy. In some cases, chemotherapy, radioactive colloids, immunotherapy or biologic response modifiers are instilled directly into the peritoneal cavity. Some limited success in selected cases has also been reported using whole abdominal radiation (7). All of these techniques have resulted in improved local control and, in some cases, prolonged survival though the impact on total cure has been limited. Even though aggressive local treatment has proven somewhat beneficial, there have been increasing reports of distant recurrences such as the central nervous system (3).

Recent articles have reported cases of metastases to the cerebral and cerebellar parenchyma, the orbit and retro-orbital space (8,9). Paraneoplastic

cerebellar degeneration associated with Purkinje cell antibodies has also been reported (10).

As the aggressive management of ovarian carcinoma continues to improve local control and lengthen survival, future therapy may need to focus on distant sites once felt not to be involved.

References

1. Boring C, Squires T, Tong T. Cancer statistics. CA 1991;41:19-36.
2. Gallion HH, Liu PY, Alberts DE, et al. Phase II trial of Amonafied in previously treated patients with advanced ovarian cancer: a Southwest oncology group study. Gynecol Oncol 1992;46(2):230-2.
3. Grendys EC, Tang RA, Gershenson DM. Choroidal metastasis from primary ovarian carcinoma. Gynecol Oncol 1992;46(2):251-3.
4. Bergman F. Carcinoma of the ovary. A clinicopathological study of 86 autopsied cases with special reference to mode of spread. Acta Obstet Gynecol Scan 1966; 45:211-31.
5. Larson DM, Copeland LJ, Moser RP, et al. Central nervous system metastasis in epithelial ovarian carcinoma. Cancer 1986;68:746-50.
6. Hauksson A, Bynke H, Trope C. A serous ovarian cystadenocarcinoma metastatic to both eyes. Acta Obstet Gynecol Scand 1987;66:187-8.
7. Dembo AJ, Bush RS. Ovary: Treatment of Stages III and IV. Choice of postoperative therapy based on prognostic factors. Int J Radiat Oncol Biol Phys 1982;8:893.
8. Dauplat J, Nieberg K, Hacker NF. Central nervous system metastases in epithelial ovarian carcinoma. Cancer 1987;60:2559-62.
9. Malviya VK, Blessed W, Lawrence WD, et al. Retro-orbital metastases in ovarian cancer. Gynecol Oncol 1989;35;120-3.
10. Greenlee JE, Brashear R. Antibodies to cerebellar Purkinje cells in patients with paraneoplastic cerebellar degeneration and ovarian carcinoma. Ann Neurol 1983; 14:609-13.

Omni
Claims Processing

We are a medical billing service designed to meet all of your billing needs.

Call:
(304) 744-4332

Omni Claims Processing
316 Joseph Street
South Charleston, WV 25303-2030

New Manuscript Guidelines

All scientific manuscripts should be submitted on disc in the following languages: Wordperfect 4.2, 5.0, and 5.1; Word; Word for Windows; and WordStar. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

No more than 25 references will be published free of charge and they must be presented in the style based on the formats used by the U.S. National Library of Medicine in *"Index Medicus."*

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Medical Grand Rounds

West Virginia University Health Sciences Center
Edited by Irma H. Ullrich, M.D., Professor of Medicine, Section of Endocrinology and Metabolism

Therapy for congestive heart failure in the late 20th century

DISCUSSANTS:

L. PHILLIPS MAXWELL, M.D.
Associate Professor of Medicine, Section of Cardiology

ABNASH JAIN, M.D.
Professor of Medicine, Section of Cardiology

Abstract

Ten to 15 years ago, the thrust of research in the treatment of congestive heart failure centered around finding new inotropic agents. While initially useful, these agents given chronically actually accelerated left ventricular failure and were associated with excess mortality. Recently, it has been learned that altering the body's response to heart failure is more beneficial compared to attempts to stimulate left ventricular inotropic function. Such altering of the neurohumoral responses to heart failure has been associated with improvements in both morbidity and mortality.

Introduction

Congestive heart failure (CHF) is a syndrome representing a pathophysiologic state in which an abnormality of cardiac function is responsible for failure of the heart to circulate blood commensurate with the requirements of the metabolizing tissues.

Systolic dysfunction is characterized by a loss of stroke volume and subsequently a loss of cardiac output which represents a loss of contractile or inotropic function of the ventricle. This usually is a consequence of a loss of myocardium with chamber dilatation. Pathologic etiologies include ischemic heart disease, hypertensive heart disease, valvular heart disease, and dilated types of idiopathic cardiomyopathy (1,2).

Diastolic dysfunction is characterized by a loss of ventricular compliance (1,2). As a result of forceful systole, there is an excessive consumption of high energy phosphate, i.e. ATP. The subsequent diastolic phase with ventricular filling is impaired because the uncoupling or dissociation of calcium from Troponin-C which results in the dissociation of actin from myosin is also high energy phosphate dependent. The ventricle in a sense resists filling as a consequence of impaired relaxation. Pulmonary congestion often results. Echocardiogram with Spectral Doppler shows a characteristic increase in the mitral valve "A" wave (atrial systole) velocity with a reversal of the E:A ratio. Etiologies include ischemia and left ventricular hypertrophy of any cause. Mechanical outflow obstruction of the left atrium, like that seen in mitral stenosis, results in similar pathology.

Altered neurohumoral responses

Physicians today have a much better understanding of the neurohumoral responses to heart failure. As a result of abnormal perfusion, end organ sensors such as carotid bodies, juxta-glomerular apparatus, hypothalamus, etc., respond as if the individual were hypovolemic rather than volume overloaded as is the case in heart failure. There is an increase in sympathetic tone and circulating catecholamines and the renin-angiotensin system is activated with increased aldosterone production. In addition, antidiuretic hormone, (arginine vasopressin), and atrial natriuretic factor levels are increased (1,2).

These neurohumoral responses result in increased systemic vascular resistance (afterload), veno-constriction, decreased baroreceptor responsiveness, decreased glomerular filtration, and salt and fluid retention. With a fall in cardiac output, the arterial-venous oxygen difference increases as the tissues attempt to maintain their nutrient supply with a decreased delivery rate. Salt and fluid retention results in excessive preload which causes pulmonary venous and peripheral congestion, i.e. pulmonary edema and dependent peripheral edema with organ congestion.

Left ventricular performance is further impaired with the increase in preload and afterload. These neurohumoral reflexes result in a chain reaction or a negative feedback loop which is like a vicious circle of related events. It is our understanding of these relationships and our ability, or lack thereof, to interrupt these related events that allows us to relieve the signs and symptoms of heart failure. Rather than the ventricular contractile state, the previously described cascade of events and its subsequent alteration of blood-flow distribution determines clinical status. This is why the left ventricular ejection fraction correlates well with survival, but it correlates poorly with exercise performance (1,2).

Angiotensin II and arginine vasopressin (AVP) are two important hormones which worsen the hemodynamics associated with heart failure. Angiotensin II is a potent arteriolar constrictor. It stimulates the release of aldosterone and AVP, facilitates norepinephrine transmission in the autonomic nervous system, and

stimulates the release of epinephrine from the adrenal medulla.

Arginine vasopressin potentiates the vasoconstriction effects of norepinephrine and angiotensin II. These effects are magnified in heart failure because usual circulation reflex controls are impaired. To date, AVP is the most potent circulating vasoconstrictor hormone (1,2).

Inhibition of these two hormones would alleviate their deleterious effects and thereby improve the altered hemodynamics associated with heart failure. Improved loading conditions of the heart would lead to improved ventricular performance without any direct inotropic effect.

Inhibition of angiotensin II alone results in arteriolar dilatation and decreased central nervous system activity. These effects occur as a result of reduced aldosterone production and reduced norepinephrine synthesis and release. Vascular tissue is "desensitized" to constrictors and prostaglandin production is increased with subsequent venodilatation.

Pharmacologic agents

Angiotensin converting enzyme inhibitors (ACE-I) are available in both oral and intravenous dosage forms to inhibit angiotensin II synthesis. ACE-I are considered mixed vasodilators because they affect both arterial and venous tone, i.e. afterload and preload respectively. Other mixed vasodilators are nitroprusside, which is available only in intravenous form, and prazosin, which is available only in oral form. Prazosin, a peripheral alpha I receptor blocker, is associated with the development of tolerance after several weeks when used as a vasodilator. While prazosin may initially prove useful in the treatment of heart failure, its effectiveness is lost with time (2).

The nitrates are considered pure venodilators when given orally. On the other hand, any arterial dilating effect would be seen with sublingual, intravenous, or intra-arterial (intracoronary) use.

Hydralazine and minoxidil are examples of pure arterial dilators. The usefulness of minoxidil is limited by its associated side effect of fluid retention.

Earlier observational studies have examined the use of either hydralazine or nitrates, specifically isosorbide dinitrate (ISDN), alone in heart failure. Improvements in cardiac output and pulmonary venous congestion were noted respectively. While improved clinical status and exercise performance were noted, no improvement in mortality was noted (2,3,4).

Early studies using either captopril or enalapril also showed improvements in clinical status and exercise performance. These studies were small in number and of short duration. Mortality reduction assessments were not possible (3,4).

Congestive heart failure studies

The initial mortality study was from the first Veterans Heart Failure Trial (VeHeFT-I) published in 1986 (5). This prospective study randomized men after treatment with digoxin and diuretic therapy to either placebo, prazosin 20 mgs. daily, or the combination of hydralazine 300 mgs. daily and ISDN 160 mgs. daily (both given in divided doses every six hours).

After an average follow-up of 2.3 years, only the hydralazine and ISDN group experienced a significant reduction in mortality. The CONSENSUS (6) Trial Study Group found similar improvement and cumulative mortality with the ACE-inhibitor enalapril. Patients with severe congestive heart failure were randomized to either placebo or 2.5 mgs. to 40 mgs. of enalapril a day given in divided doses twice daily. All patients were treated with digoxin and diuretics. Those treated with enalapril who developed renal failure had the predisposing factors of treatment with high-dose diuretics, hyponatremia, or pre-existing renal impairment before the institution of enalapril therapy. The improvement in mortality found with enalapril therapy was related to a slowing of the progression of heart failure.

To lessen the risk of renal failure with enalapril, the initial dose protocol was revised. Instead of starting with 5 mgs. twice daily, the high risk groups were started with 2.5 mgs. once daily with the next higher dose being 2.5 mgs. twice daily.

The VeHeFT-I and CONSENSUS assessed the improvement and survival in those individuals with severe (New York Heart Association functional Class IV) congestive heart failure. The Ve-HeFT-II (7) and Studies Of Left Ventricular Dysfunction (SOLVD) (8) trials assessed the survival of patients with less severe forms of congestive heart failure. While these patients had a left ventricular ejection fraction $\leq$ 35%, their New York Heart Association function class was either Class II or Class III.

VeHeFT-II compared the combined treatment of hydralazine and ISDN versus enalapril, and these therapies were compared to placebo. All patients received therapy with sodium restriction, diuretics, and digoxin as necessary. Both treatment arms were associated with significant improvement in mortality compared to placebo. The enalapril treatment arm had a 28 percent lower mortality at two years. The hydralazine and ISDN treatment method's improvement in mortality was associated with both an improvement in the left ventricular ejection fraction, increased exercise tolerance, and a slowing of the progression of congestive heart failure. The enalapril arm also had similar improvements, but enalapril's lower mortality rate was associated with a decreased incidence of sudden cardiac death.

The SOLVD (8) trial enrolled patients similar to those in the VeHeFT-II trial and compared enalapril to placebo therapy. All patients were treated with sodium restriction, diuretics, and digoxin as necessary. Once again, the enalapril arm was associated with improvement in mortality. In contrast to the VeHeFT-II results, the improvement in mortality was related to the slowing of the progression of congestive heart failure and there was no apparent reduction in death from sudden cardiac death.

The SOLVD (9) trial also included a prevention arm. Patients enrolled in this trial had a left ventricular ejection fraction of $\leq$ 35 percent, but they were asymptomatic and were in the New York Heart Association functional Class I. The enalapril group experienced a significantly reduced incidence of heart failure with a lower number of related hospitalizations compared to the placebo group. While there was a trend toward fewer

deaths due to heart disease in the patients treated with enalapril, there was no significant decrease in mortality rates.

In contrast to the results from the prevention arm of the SOLVD trial, the SAVE (10) trial showed that treatment with captopril after an acute myocardial infarction in asymptomatic patients with ejection fractions of 40 percent or less was associated with a statistically significant improvement in survival with reduced morbidity and mortality due to major heart related events. These benefits in survival were observed regardless of the form of treatment for the acute myocardial infarction, i.e. thrombolytic therapy, aspirin, or beta blockers as well as in those who did not receive any of these therapies.

Another survival trial following acute myocardial infarction was the CONSENSUS II (11) trial. Unlike the SAVE trial, therapy was instituted within 24 hours of the acute myocardial infarction rather than after three days. Additionally, the follow-up was only six months versus 42 months in the SAVE trial. No survival benefit was found with enalapril treatment in the CONSENSUS II trial. Controversy exists in the explanation of the differences between the SAVE trial and the CONSENSUS II trial. The SAVE trial used captopril instead of enalapril. The SAVE trial had a longer follow-up, but institution of therapy with captopril was delayed.

These and other studies (12) have firmly established the usefulness of ACE-inhibitors in the treatment of heart failure. Vasodilating therapy is now one of the most important forms of therapy for heart failure due to its ability to reverse the negative effects of the neurohumoral responses.

Other therapies

In addition to the methods already discussed, there are other forms of therapy useful for heart failure, such as the phosphodiesterase-III inhibitors amrinone and milrinone.

The prospective, randomized, milrinone, survival evaluation (PROMISE) trial was undertaken to evaluate the effects of milrinone as a chronic therapy on the survival of patients with Class IV heart failure (13). Due to the fact that there was a 28% higher mortality in patients treated with milrinone compared to placebo, this trial was terminated prematurely. In addition, because of the increase in fatal arrhythmias with milrinone therapy, only the intravenous form for short-term use is available. There is also concern the progression of heart failure may be accelerated with the use of phosphodieterase-III inhibitors, so these agents are only useful for the care of acutely-ill hospitalized patients (14).

In the past, the usefulness of digoxin in the treatment of congestive heart failure has been questioned, but two recent studies have re-affirmed the usefulness of digoxin therapy. The first (15) was the prospective randomized study of ventricular failure and the efficacy of digoxin. Digoxin therapy was withdrawn in those patients with stable congestive heart failure. All patients had normal sinus rhythm. Exercise time worsened in those who had their digoxin withdrawn; and worsening of heart failure was also noted. These therapeutic failures occurred in 39 percent of those who had their digoxin discontinued versus 19 percent of those who did not. A shorter time to therapeutic failure was also noted in those without digoxin therapy and these individuals also developed worsening of the left ventricular ejection fraction with increases in weight, heart rate, BUN and serum creatinine.

A similar study (16) was undertaken, but this time with patients who were also treated with ACE inhibitors. Once again, all patients had normal sinus rhythm. The results were the same as previously described.

New directions

Several "new" therapies are being evaluated for the treatment of congestive heart failure. Therapeutic classes of drugs include beta blockers, inhibitors of atrial natriuretic peptide degrading enzymes and inositol triphosphate pathway inhibitors (2,17,18,19).

So called "low dose" beta blockers have been found useful in the treatment of congestive heart failure (17). Some investigators have found improved functional status with increases in exercise capacity and left ventricular ejection fraction. The role of beta blockers in these improvements is not clear. Results may reflect a blunting of the tachycardia that often occurs with heart failure, or there may be some "protection" from one's own sympathetic tone. An "up-regulation" of beta receptors may also be important.

Due to the difficulty in controlling the patient's preload with heart failure and because of the associated negative inotropic effect of beta blockers, this class of drug is not yet approved for the treatment of heart failure. Further studies will be necessary to clarify the usefulness of beta blockers for this indication.

Candoxatril is an inhibitor of metalloendopeptidase which is the major atrial natriuretic peptide degrading enzyme (18). The use of oral candoxatril in the treatment of congestive heart failure has been associated with increased atrial natriuretic peptide levels 12 hours after the last dose of candoxatril. This effect was associated with a significant decrease in levels of serum aldosterone and a significant decrease in body weight. Further studies are ongoing to determine the long-term usefulness and safety of this medication for the treatment of heart failure.

Flosequinan is a unique new vasodilator (19). Its effects are relatively selective for vascular smooth muscle with interference of the inositol triphosphate pathway, resulting in direct arterial and venous dilatation similar to the combined effects of hydralazine and ISDN. This agent has an advantage over ACE-I inhibitors in that it is not associated with the annoying cough that frequently prevents the use of ACE-I in many patients.

Heart failure that is due to predominantly left ventricular diastolic dysfunction requires a different treatment approach compared to the previous discussion of the use of vasodilators in correcting systolic failure (3). Individuals with predominantly diastolic dysfunction often have normal systolic function. Treatment is directed toward preventing or alleviating pulmonary congestion, and diuretics and venodilatation are useful in this regard. However, excessive preload reduction results in azotemia and orthostatic hypotension. If the diastolic dysfunction is due to

myocardial ischemia, then therapy in this regard is very useful. Calcium channel antagonists, as a group, have positive lusitropic (myocardial relaxation/compliance) action with a direct effect on the improvement of diastolic relaxation. Heart rate control and the maintenance of sinus rhythm are also very important.

On the other hand, excessive heart rate control in the absence of improving diastolic relaxation with associated improvement in stroke volume, will actually decrease cardiac output. Control of the relatively excessive systolic contraction will indirectly improve diastolic relaxation. Blood pressure control and therapy to cause regression of left ventricular hypertrophy are also useful. Inotropic agents are not very beneficial if the systolic function is preserved.

In summary, recent improvements in both the understanding of the adverse neurohumoral responses to congestive heart failure combined with therapy which corrects these abnormalities have significantly improved physicians' ability to treat heart failure. While these new therapies have resulted in improved survival in patients with congestive heart failure, many of these individuals have very poor left ventricular function and many die awaiting heart transplantation. Newer therapies will continually be needed. Additionally, the prevention of ischemic and congestive heart disease remains as important as ever, considering the aging of our population with its associated increased risk of these cardiac diseases.

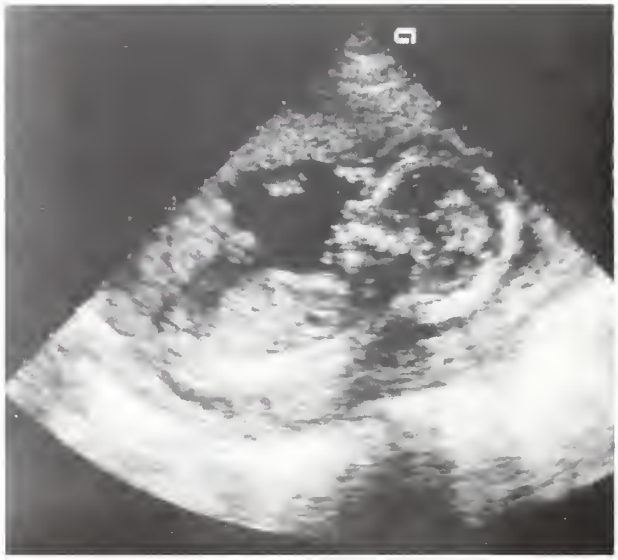
References

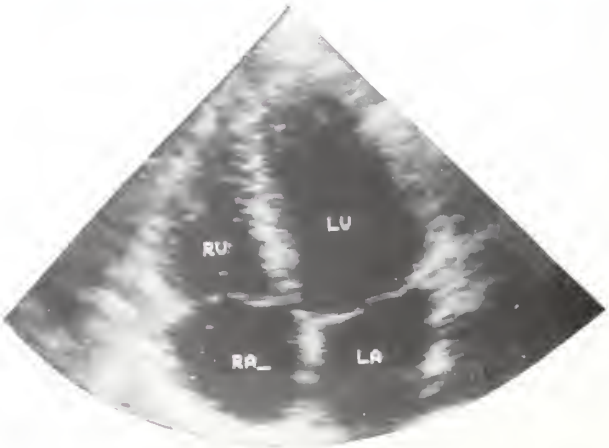
1. Parmley WW. Pathophysiology of congestive heart failure. Clin Cardiol 1992; 15, (Suppl I), I-5-I-12.
2. Braunwald E, editor. Heart Disease. 4th ed. Philadelphia: W. B. Saunders, 1992: 393-520.
3. Captopril Multicenter Research Group. A placebo-controlled trial of captopril in refractory chronic congestive heart failure. J Am Coll Cardiol 1983;2:755-63.
4. The Captopril-Digoxin Multicenter Research Group. Comparative effects of therapy with captopril and digoxin in patients with mild to moderate heart failure. JAMA 1988; 259:539-44.
5. Cohn JN, Archibald DG, Ziesche S, et al. Effect of vasodilator therapy on mortality in chronic congestive heart failure: results of a Veterans Administration Cooperative Study. N Engl J Med 1986;314:1547-52.
6. The CONSENSUS Trial Study Group. Effects of enalapril on mortality in severe congestive heart failure: results of the Cooperative North Scandinavian Enalapril Survival Study (CONSENSUS). N Engl J Med 1987;316:1429-35.
7. Cohn JN, Johnson G, Ziesche S, et al. A comparison of enalapril with hydralazine-isosorbide dinitrate in the treatment of chronic congestive heart failure. N Engl J Med 1991;325:303-10.
8. The SOLVD investigators. Effect of enalapril on survival in patients with reduced left ventricular ejection fraction and congestive heart failure. N Engl J Med 1991;325:293-302.
9. The SOLVD Investigation. Effect of enalapril on mortality and the development of heart failure in asymptomatic patients with reduced left ventricular ejection fractions. N Engl J Med 1992;327:685-91.
10. Pfeffer MA, Braunwald E, Ma LA, et al. Effect of captopril on mortality and morbidity in patients with left ventricular dysfunction after myocardial infarction: results of the Survival and Ventricular Enlargement Trial (SAVE Trial). N Engl J Med 1992;327:669-77.
11. Swedberg K, Held P, Kjekshus J, Rasmussen K, Rydénl, Wedel H. Effects of the early administration at enalapril on mortality in patients with acute myocardial infarction — results of the cooperative New Scandanavian Enalapril Survival Study II (CONSENSUS II). N Engl J Med 1992;327:678-84.
12. Fonarow GC, et al. Effect of direct vasodilation with hydralazine versus angiotensin-converting enzyme inhibition with captopril on mortality in advanced heart failure: the Hy-C trial. J Am Coll Cardiol 1992;19:842-50.
13. Packer M, Carver JR, Rodeheffer RJ, et al. Effect of oral milrinone mortality in severe chronic heart failure. The PROMISE Study Research Group. N Engl J Med 1992; 325:1468-75.
14. Om A, Hess M. Inotropic therapy of the failing myocardium. Clin Cardiol 1992; 16,5-14.
15. Packer M, Gheorghiade M, Young JB, et al. Randomized, double-blind, placebo-controlled, withdrawal study of digoxin in patients with chronic heart failure treated with converting-enzyme inhibitors. J Am Coll Cardiol 1992;19:260A.
16. Young JB, Uretsky BF, Shahidi FE, Yellen LG, Harrison MC, Jolly MK. Multicenter, double-blind, placebo-controlled randomized withdrawal trial of the efficacy and safety of digoxin in patients with mild to moderate chronic heart failure not treated with converting enzyme inhibitors. J Am Coll Cardiol 1992;19:259A.
17. Sabotka P, Gunnar RM. The use of beta-blockade therapy in treatment of congestive heart failure. Clin Cardiol 1992;15,630-5.
18. Elsner D, et al. Effectiveness of endopeptidase inhibition (Candoxatril) in congestive heart failure. Am J Cardiol 1992;70:494-8.
19. Haas GJ, Binkley PF, Carpenter JA, et al. Central and regional hemodynamic effects of flosequinan for congestive heart failure. Am J Cardiol 1989;63:1354-9.

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time





sound

Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

Successful Money Management Seminars

FOR WEST VIRGINIA STATE MEDICAL ASSOCIATION MEMBERS AND THEIR SPOUSES

- Charleston May 12, May 19 and May 26
- Morgantown June 9, June 16, and June 23
- Wheeling July 14, July 21 and July 27
- Huntington September 8, September 15 and September 22
- Beckley October 13, October 20 and October 27
- Parkersburg November 3, November 10 and November 17

Comprehensive Seminar Agenda

SESSION 1

- Your Foundation for Financial Independence
  - Why Everyone Needs Financial Planning
  - Six Main Objectives of Financial Planning
  - Reallocating Your Income
  - The Success Triangle™
  - Six Main Reasons People Fail Financially
  - Take Advantage of Your Lifetime Earning Power
  - Become Financially Independent;
  - The Eighth Wonder of the World—Compound Interest
  - The Effects of Inflation
  - Your Tax Bracket—How it Affects Your Financial Plan
- Putting Your Dollars to Work—Part I
  - Importance of Cash Reserves
  - Types of Cash Reserves
  - Restricted Cash Reserves
  - Tax-Deferred Fixed Annuities
  - Fixed-Income Securities
    - Government Securities
    - Corporate Bonds
    - Municipal Bonds
- Putting Your Dollars to Work—Part II
  - Equity Investments
    - Common Stock
    - Preferred Stock
    - Reading the Stock Tables
    - Risk Factors
    - Managed Accounts
  - Ten Steps to Financial Success
    - Your Personal Financial Plan—The Key to Your Success

SESSION 2

- Putting Your Dollars to Work—Part II
  - Mutual Funds
    - Families of Funds
    - Types of Funds
    - Dollar Cost Averaging
    - Selecting Specific Funds
    - Asset Allocation
  - Guaranteed Versus Equity Investments
  - Limited Partnerships
  - Tangible Assets
  - College Funding
- Retirement Planning
  - Social Security
- 401(k) Plans
- 403(b) Tax-Sheltered Annuities
- Simplified Employee Pensions (SEP-IRA)
- Individual Retirement Accounts (IRA)

SESSION 3

- Retirement Planning (continued)
  - Tax-Deferred Variable Annuities
  - Systematic Withdrawal Programs
  - Risk Management
  - Insuring Your Most Valuable Asset
  - Long-Term Health Care
  - Life Insurance
  - Enhancing Your Pension Benefits with Life Insurance
  - Estate Planning
    - Objectives of Estate Planning
    - Probate-Should it be avoided?
    - Living Revocable Trusts

SESSION 4

Optional

Everyone attending this seminar is entitled to a personal financial planning consultation after the conclusion of Session Three. This is your opportunity to ask specific personal questions regarding your financial future at no additional cost.

ENROLLMENT FORM

(Member's Name) _____ (Spouse's Name) _____

(Mailing Address) _____

(Telephone Number) _____ (Seminar Location I Plan To Attend) _____

Call (304) 925-0342 for more information.

Registration Fee: $250 (member) $125 (spouse)

* Make check payable to West Virginia State Medical Association
* Mail enrollment form and fees to: West Virginia State Medical Association
  P. O. Box 4106
  Charleston, WV 25364

President's Page

Robert P. Pulliam MD.

We - Them, Sunshine and the Orange and Black

As a new legislator, I quickly learned that for some reason there are two types of delegates -- we and them! Them are the leadership, and we are the rest (about 75 of the 100 delegates).

Them set the agenda, choose the issues on which we will be able to vote, and decide when the issues will be voted on. Them twist arms and make deals to change votes. It's almost as if the two groups have different agendas for West Virginia.

Them meet in secret unannounced meetings, decide policy, then attempt to use the pressure element of time to force approval on legislation, frequently without adequate opportunity to review and discuss it. Even though it is the law to have open meetings, sunshine frequently doesn't penetrate the heavy smog that constantly pervades the state capitol.

The highlight of the session may have been Bill #2701 by Delegate Arnold Ryan concerning the new Summers County High School. This bill states that:

"The students eligible to attend the new Summers County High School are entitled to vote for their choice, without restriction, of a school mascot and school colors. The county board of education shall prepare ballots for this election or vote, determine the procedure for election and conduct the election no later than one year before the scheduled opening of the new high school. The choice of mascot and school colors shall be determined by a simple majority and no student may be permitted to cast more than one ballot."

This bill entitles the students of the new Summers County High School to vote for their choice WITHOUT RESTRICTIONS. To vote without restrictions -- what a pleasure that would be! Numerous bills were not considered on their merit or blocked completely from consideration by the leadership.

I was asked immediately following the last night of the regular session for my evaluation as a freshman delegate. I described the Legislature as a circus, or better yet, a big black box where no light shines. Hopefully, as time passes and the stress of the session wanes, my opinion will moderate -- I doubt it!

Delegate Robert P. Pulliam, M.D.

Congressional need

Do I want too much? Or am I getting too little? Not bad questions to ask when you are feeling a little needy or neglected for any reason.

The same questions might need to be asked by the American public in regard to medical care. Urged on by the vote hunger of politicians and the crocodile tears of the liberal media, members of the public have been convinced that when they fall ill, they are entitled to or somehow merit the use of every weapon in the medical arsenal.

The escalating ferocity of present debate on the subject of medical care by unexpected factions which find themselves seriously affected by the possible outcome, strongly suggests that too much has been promised -- a situation hardly new to the game of politics. And strangely, we keep hearing this manufactured situation referred to as a crisis in the provision of medical care.

Without exposing our sanity to the risk of serious question, we can with great assurance say there is no crisis, there is not even a problem in the provision of medical care. We have experienced no problem in providing the amount of medical care currently being offered; we have the capability to provide a much greater amount of medical care if it is needed; and we can even provide less medical care if, as seems to be the case, that is what is demanded.

We possess great flexibility in regard to the amount of medical care we can provide. As an industry, we are not unique in that flexibility. Consider General Motors, their product is automobiles, ours is medical care. They make a certain number of vehicles each year but could make many more or many less according to the demand. We have no crisis in regard to our ability to provide any amount of medical care.

What we have is a political problem stemming from a chronic failure to be honest with constituents by members of Congress and residents of the White House. Political promises have created a raging demand for medical care. Now, these hapless promise-givers look helplessly at each other and ask "What do we do now?"

It seems obvious that no one is willing to pay for the quantity of medical services promised and now demanded. Redistribute the quantity of medical care now being paid for? A political no-no that! Attempt to take something away from any segment of the voting public and suffer the consequences at the next election.

Our own Senator Rockefeller, recognized via his years as chairman of the Pepper Commission as the leading health authority in Congress, discovered in his work the bitter political truth that there is no acceptable political solution to the problem of satisfying public demand for medical care. He now seems intent on laying at the feet of President Clinton the blame for any failure to meet those demands.

It is discernible and logical that any service or product will cost the same under other or different methods of payment. This means that short of rationing, there appears to be no answer whatsoever to the payment problem and rationing, as a political solution to the question of how medical care can be provided free or nearly free to all, is sure to be acceptable to no one.

Who can blame the American public for wanting too much? We have been promised too much! Those not so blameless for wanting too much -- too much voter fidelity, too much political longevity, too many votes -- are our members of Congress.

– SDW

A different perspective on obstetrical data

I am writing in regard to Dr. Robert Pulliam's article "Evaluation of the Obstetrical Care System in West Virginia" that appeared in the January issue of the *West Virginia Medical Journal.* First of all, I would like to publicly thank Dr. Pulliam for elevating the importance of the issue of obstetrical care in our state. He has long been a strong voice for and an active provider of care for West Virginia women.

I am, however, concerned that the article apparently misinterpreted some current definitions, as well as data collected and provided by the West Virginia Bureau of Public Health.

For example, in the section "Health Indicators," definitions of both fetal mortality rate and neonatal death are incorrect. The article states that fetal mortality rate is "the birth of a fetus with no evidence of life which weighs more than 500 grams, or measures greater than 25 centimeters in length, or is greater than 20 weeks gestational age."

A fetal death is defined by West Virginia Statute 16-5-1 as a product of human conception that shows no sign of life after complete expulsion or extraction from its mother. All fetal deaths occurring after 20 weeks or greater gestation must be reported to the Bureau's Vital Registration Office on a Report of Fetal Death form. Fetal deaths are not determined by the length or weight of the fetus.

The neonatal death definition used in the article was "the death of a live fetus which is greater than 20 weeks gestational age, weighs more than 500 grams, or has a length greater than 25 centimeters through the first 28 days of life." By state statute, a neonatal death is defined as the death of a live-born infant within the first 28 days of life. Neonatal deaths are not determined by the length or weight of the infant.

The article also misrepresents information about the fertility rate in West Virginia. According to the article, "The fertility rate (births per 1,000 women) for ages 15-44 is 56 percent, which is also significantly lower than the U.S. rate of 67.2 percent." The article also uses the word "percent" when discussing fertility among 15-19-year-olds.

The use of the word "percent" in these statements is incorrect. As stated in the parentheses, the fertility rate represents the number of births per 1,000 women in specific age groups (i.e. 15-19). In addition, comparison is made between the 1990 West Virginia fertility rate among 15-44-year-old women and the 1988 U.S. rate among women in this group. The different years for these rates was not made clear.

Table 7, "Prenatal Care Access by Trimester (%)," also inaccurately projects a dramatic increase in the percentage of women receiving first trimester prenatal care in West Virginia. The table uses vital statistics from 1986-90 to show that first trimester care ranged from a low of 68.5% of women receiving that care in 1987 to a high of 71.3% in 1990.

The table also includes a projection that 84% of all women will receive first trimester care in 1993, based on an unidentified survey of a southern county. However, vital records for 1992 show a provisional rate of 73.6% of women giving birth after receiving first trimester care. Cumulative 1993 records show a rate of 72.9% to date.

Dr. Pulliam expresses concern about the availability of data identifying health care providers who have delivered babies in West Virginia. This indeed has been a problem in the past. In order to better identify these individuals, the Vital Registration Office has recently established a coding system to identify the health care provider on all state birth certificates. This has been in place since late 1991, and 1992 data will be available for analysis by April 15.

While there has been ongoing confusion due to reports with differing numbers of obstetrical providers statewide, and while the number does appear to be higher than originally thought, the fact remains that there is still not adequate prenatal care available throughout all of West Virginia. According to the Statewide Perinatal Task Force Report released last fall, as many as 11 counties do not have prenatal care available within their boundaries for their residents. Those counties include Boone, Braxton, Brooke, Gilmer, Hardy, Mineral, Morgan, Pleasants, Pocahontas, Tyler and Wirt. This discourages early prenatal care, especially among many of the women (including adolescents) who need it most.

The problem of inadequate prenatal and obstetrical care will not be easily resolved in West Virginia, but we are making improvements. Working with physicians such as Dr. Pulliam, and with other health care providers, we will continue to do so to the best of our abilities.

William T. Wallace Jr., M.D., M.P.H.
Commissioner
West Virginia Bureau of Public Health

American Medical Association
Physicians dedicated to the health of America

For Your Benefit

AMA renews call for physician input on health care reform

During the crucial first 100 days of the Clinton Administration, the American Medical Association stepped up its involvement in the health system reform debate. AMA's goal: to ensure that patients' needs remain the focus of system reform.

The AMA organized an unprecedented two-day Washington summit, "A Time for New Partnership," on March 23-25 to encourage dialog between physicians and the Clinton Administration and Congress. Physicians from across the country gathered in Washington to hear Vice President Al Gore speak on health system reform; HHS Secretary Donna Shalala and Majority Leader George J. Mitchell (D, Maine) also addressed the physicians.

After a briefing by AMA legislative staff, the physicians visited with their representatives in Congress.

The AMA is continually working to make the voice of American physicians heard in Washington. As AMA EVP James S. Todd, MD, stated in a letter to White House senior health policy adviser Ira Magaziner, "Bring us into the process, and we can help make it work. Without the 'buy-in' of people in the front lines of health care delivery, enactment and implementation of reform will be much more difficult."

Contest boosts AMA's anti-tobacco crusade

AMA and U.S. Surgeon General Antonia Novello, MD, are sponsoring a nationwide contest to increase children's awareness of the dangers of smoking. AMA President John L. Clowe, MD, said the contest is part of the AMA's and the surgeon general's continued campaign to achieve a smokefree environment by the year 2000.

The contest is designed to combat the tobacco industry's "spending millions of dollars in advertising to encourage young children to start smoking."

AMA and the surgeon general last year sponsored a protest march in Chicago against cigarette advertising that targets children. They also demanded that R.J. Reynolds Co. drop ads featuring the company's most effective marketing tool — the cigarette-smoking Old Joe Camel that appeals to children.

The nationwide contest, called "Say No, Old Joe," is aimed at the Camel cartoon. Studies published in the December 10, 1991 JAMA showed children six years of age and older found the character just as recognizable as the Disney Channel's Mickey Mouse logo. Old Joe Camel's appeal increased smoking of that brand among children from five percent to 32 percent during a three-year period, the studies found.

"The AMA will continue its fight to eliminate underage smoking and put pressure on cigarette manufacturers who use deplorable advertising tactics to entice children to begin smoking," said Lonnie R. Bristow, MD, AMA vice chair. "Maybe Old Joe Camel has taken his last puff?"

Prepared by the Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

OUR AREA OF EXPERTIS

Cancer crosses all cultures and all nationalities without exception. So it stands to reason that the treatment and eventual cure of a condition experienced worldwide would require talent and intellect from around the globe.

That's why the planners of The Arthur G. James Cancer Hospital and Research Institute, a National Cancer Institute designated Comprehensive Cancer Center, set out to staff this promising medical center with the top researchers in their field, wherever they might be found. Their search resulted in a respected team of renowned specialists from all around the world.

However, this search would never have been successful without a highly attractive institution. Designed to provide the optimum environment for the development and application of effective cancer treatments, The James hous remarkable research facilit within the same building as equally excellent treatment c ter. Because the organizatio

ENERATION OF HOPE

THE OHIO STATE UNIVERSITY

sciences, pharmacy and veterinary medicine, has enabled research efforts to advance efficiently while benefiting from the resources of one of the nation's leading University medical programs.

Beginning with the very first blueprints, The James was designed to provide researchers with the facilities, technology and opportunity to conduct their best work. Today, it is a reality that is dedicated to offering hope to the current generation of cancer patients as well as the promise of eradication to those in the future.

VERS A LOT OF GROUND.

proach to research is so integrated, the lag time between laboratory breakthroughs and practical application is dramatically decreased. Collaboration between research teams and clinical specialists of the Comprehensive Cancer Center, which are composed of University graduate programs in chemistry, biological

THE ARTHUR G. JAMES CANCER HOSPITAL AND RESEARCH INSTITUTE

University, 300 West Tenth Ave., Columbus, OH 43210, 1-800-638-6996

©1993

AMA president to deliver address at Annual Meeting

Joseph T. Painter, M.D., who will become president of the AMA in June, will discuss the AMA's domestic violence campaign and related activities when he speaks at the WVSMA's Annual Meeting on August 21 during the Second Session of the House of Delegates.

Formerly the vice president for health policy and a professor of medicine at the University of Texas M.D. Anderson Cancer Center, Dr. Painter has been serving as president-elect of the AMA since June 1992. He had held the position of chair of the AMA Board of Trustees since June 1990, was vice chair in 1989, and has been a member of the board since 1984.

Elected to the AMA Executive Committee in 1985, Dr. Painter has served on the Finance Committee since 1984. Previously at AMA, he had chaired Work Group 6, "Payment for Services," of the Health Policy Agenda in 1983; the Council on Long Range Planning and Development from 1979-81; and Reference Committee F and the Special Committee of the House of Delegates (Finances and Structure) from 1974-75. In addition, Dr. Painter was a member of the Ad Hoc Committee on Medical Ethics from 1978-79 and was a delegate in the House of Delegates from 1971-84.

Painter

A nationally recognized authority on cancer control, Dr. Painter joined the M.D. Anderson Cancer Center faculty in 1975. He is a professor of internal medicine at The University of Texas Medical School at Houston and is a clinical associate professor of medicine at Baylor College of Medicine.

A native of Austin, Texas, Dr. Painter received his M.D. degree from the University of Texas Medical Branch at Galveston in 1949, and then completed his internship and residency in internal medicine at the Hospital of the University of Pennsylvania. Dr. Painter is a diplomate of the American Board of Internal Medicine and a past president of the American Society of Internal Medicine. A fellow of the American College of Physicians, he has also been active with the Texas Medical Association, the Texas Medical Foundation and the Southern Medical Association.

Information concerning other speakers at this year's WVSMA Annual Meeting will be published in upcoming issues of the *Journal*. A registration form for the meeting appears on page 163 and additional details can be obtained by phoning Nancie Divvens at (304) 925-0342.

New national award to honor rural physicians

The "Country Doctor of the Year," is the title of a new award which will be presented by the Country Doctor Museum in Bailey, N.C., in association with Staff Care, an interim physician staffing service based in Irving, Texas. This annual award is intended to honor a physician who symbolizes the "spirit, skill and dedication" of America's country doctors, according to Wanda Dearth, Staff Care's director.

The award recipient will receive a personalized bronze plaque depicting the award's signature logo -- a country doctor making his rounds on a horse and buggy. In addition, Staff Care will provide the honoree with an interim physician for one week at no charge -- a service normally valued at about $10,000. The interim physician will allow the Country Doctor of the Year a rare opportunity to take time off from his or her practice. The selected physician also will be presented with a personalized, custom-made leather physician's bag.

COUNTRY DOCTOR OF THE YEAR

As a special added honor, the award recipient will be recognized by the Country Doctor Museum, the only museum in the nation specifically dedicated to memorializing the contributions of America's country doctors. The museum will display a bronze plaque bearing the honoree's name, thereby securing the Country Doctor of the Year a place in the annals of rural medicine.

Nominations will be accepted through July 1, and may be submitted by physicians, health facility administrators, nurses, patients or relatives of the nominee. To obtain a nomination form, call Staff Care at (800) 685-2272 or the Country Doctor Museum at (919) 235-4165.

Legislative Reception and Briefing

At the Legislative Reception, Senate President Keith Burdette (left) discusses the latest events at the Legislature with WVSMA Executive Director George Rider. Also pictured are Senate Minority Leader Donna Boley and Delegate David McKinley talking with Barbara Sims, vice president of the WVSMA Auxiliary and a former member of the House of Delegates.

Dr. Tom Sporck, chairman of the WVSMA's Legislative Committee, asks a question while clarifying a point during the Legislative Briefing, which was held prior to the Legislative Reception.

Winnie Martin, WVSMA's director of government relations, speaks with Senators Tony Whitlow and Leonard Anderson about pending legislation.

Delegate J. D. Beane exchanges greetings with Katrina Pulliam, wife of WVSMA President Dr. Robert Pulliam (left). Talking with Dr. Pulliam are House Minority Leader Bob Burk, Dr. Rutherford Sims and his wife, Barbara.

(Right) Delegate Bill Wallace of Greenbrier County explains his views to Drs. Stephen Sebert and Stephan Thilen.

New support program offered for parents with premature infants

Valley Health Systems (VHS), an integrated network of 10 community health centers in sothwestern West Virginia, and the health care research company Hoffmann-La Roche, Inc., have expanded a pilot program called Parenting Premies to families in Huntington and the surrounding rural communities.

Through Parenting Premies, parents of premature infants can receive free education and support from VHS during the most critical stage -- just after the baby is discharged from the hospital. The structure of Parenting Premies includes group sessions and/or home visits and telephone consultations, as well as an assessment of the baby's physical condition, development and maturity. Issues covered during the program include fears related to caring for the child without on-site professional support; infant CPR training; common problems associated with premature infants (eating and sleeping cycles, crying and irritability), and premature infants' competencies.

For more information concerning Parenting Premies, phone Linda Anderson at VHS, (304) 525-3334.

Trammell named chairman of Cancer Liaison Program

S. Willis Trammell, M.D., F.A.C.S., of Charleston, was recently appointed the West Virginia state chairman of the American College of Surgeon's Cancer Liaison Program. The Cancer Liaison Program has over 2,100 volunteer physicians and is an integral part of the Commission on Cancer of the ACS.

As West Virginia state chairman, Dr. Trammell will help select and guide cancer liaison physicians throughout the area in the implementation of local cancer programs designed to improve patient care. He will also provide leadership for the annual national clinical goal of the Cancer Liaison Program; the utilization of the tumor, node, and metastasis (TNM) staging system.

For more details about the Cancer Liaison Physician Program, contact the ACS Cancer Department at (312) 664-4050.

ASIM schedules May, October seminars

The American Society of Internal Medicine will present a leadership development conference on May 20-22 in Portland, Ore., and its 37th annual meeting on October 13-17 in Washington, D.C.

For information concerning these two events, phone Melinda Klein at (202) 835-2746, ext. 266.

Conference to examine health care reform

The American College of Physician Executives is convening in New Orleans, May 12-15, for "Perspectives in Medical Management," a seminar designed to examine health care management and the issue of reform.

For more details, contact David M. DiMaggio at (800) 562-8088.

George Washington University sponsoring 12 CME programs

During the remainder of 1993, 12 CME programs will be offered at a variety of locations in the United States by The George Washington University Medical Center in Washington, D.C.

The first of these seminars, "Professional Practice in Clinical Chemistry: A Review," will be presented in Arlington Va., on April 25-29. A total of 29 credit hours in Category 1 of the AMA's Physician Recognition Award will be available.

Further details about this seminar and the other upcoming workshops can be obtained by contacting Maria Gorrick at (202) 994-4285.

Otolaryngologists to meet May 28-31

The 11th National Annual Spring Meeting of the West Virginia Academy of Otolaryngology-Head and Neck Surgery, Inc. will be conducted May 28-31 at The Greenbrier in White Sulphur Springs.

Twelve credit hours of CME in Category 1 of the AMA's Physician Recognition Award will be offered, and additional details can be obtained by phoning F. T. Sporck, M.D., at (304) 342-0124, ext. 132.

Revenue Optimization

What is Revenue Optimization?
Revenue Optimization addresses the fundamentals which govern your gross revenue and, therefore, your net income.

FEE ANALYSIS
- Your fees are converted to a relative value basis using the Systemetrics-McGraw/Hill relative value system.

CODING/REIMBURSEMENT ANALYSIS
- We analyze and evaluate your procedure code usage (and non-usage), including levels of service for the office, hospital, consultation and ER/Outpatient service as well as your use of modifiers.
- We review your insurance claim forms and your EOBs to find ways to maximize your reimbursements, minimize reductions and denials, and minimize the chance of audit.

MEDICARE/RBRVS
- The primary function is to protect your revenue under both par and non-par status, enabling you to make a rational and objective decision about your participation status with Medicare.
- In the process, we calculate your Medicare allowed amount and the co-payment amount for every procedure under both par and non-par status. RBRVS Analysis is included, showing you the effect of RBRVS on each code you use and on all codes collectively.

ON-SITE CODING/ REIMBURSEMENT
- If your personnel needs hands-on help, we come to you. We "audit" your complete reimbursement system including: procedure coding, diagnosis coding, charges, claims filing, reimbursements, and chart documentation. If needed, we will provide classroom and hands-on training for individuals or your entire staff.

YOUR SATISFACTION IS GUARANTEED
- If we do not help or if you are not satisfied with the results of your analysis — your money will be refunded!

America's Premier Consulting Firm Advising Physicians Throughout Our Nation Since 1956

RCFA Physician Managers Inc.

9724 Kingston Pike, Suite 1200
P.O. Box 23590
Knoxville, TN 37933-1590

Professional Practice Planners

332 Fifth Avenue • Suite 213
McKeesport, Pennsylvania 15132

Call Stan Pollock,
DMD, CFP, PHD, CPBC, CBA

(412) 673-3144 • 1-800-635-4040

The West Virginia State Medical Association's

1993 Annual Meeting

August 18-21, 1993

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up Now!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

For more details about other area hotels/motels, contact the WVSMA at 304-925-0342. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1993 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code _____

Specialty _____

Payment by: Check Visa MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	____
	non-member	$175	____
Additional:			
Thursday, Aug. 19 Lunch and Learn (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
Friday, Aug. 20 WESPAC Luncheon (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
		TOTAL:	____

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

May 1 - First Generation Loss Control Seminar, South Charleston

May 20 - Marbury v. Madison Loss Control Seminar, Morgantown

CAMC/WVU Health Sciences Center - Charleston

May 4 - "Principles and Methods of Head and Neck Surgery," Haskins K. Kashima, M.D., F.A.C.S., (sponsored by the WVU Dept. of Surgery and the Eye and Ear Clinic of Charleston, Inc.) 5:30 p.m., Faculty Lounge, 4th floor, WVU Health Sciences Center

May 5 - "Third Annual Perinatal Issues," Charleston Marriott

May 6 - "Train the Trainer in Fetal Monitoring," WVU Health Sciences Center Auditorium

May 6 - "Congenital Infections," (teleconference), WVU Health Sciences Center and satellite locations

May 7 - "Traumatic Brain Injury," WVU Health Sciences Center Auditorium

May 8 - "PALS Recertification Review," Room 2000, WVU Health Sciences Center

May 13 - "Neonatal Cardiac Function and Congenital Heart Anomalies," (teleconference), WVU Health Sciences Center and satellite locations

May 13-14 - "PALS Provider Course," Room 2000, WVU Health Sciences Center

WVU Health Sciences Center - Morgantown

April 24 - "Controversies in Geriatrics and the Roaring River," Lakeview Resort and Conference Center, Morgantown

May 1 - "Current Concepts in Cancer Care for the Non-Oncologist," (sponsored by the WVU Office of CME and Monongalia General Hospital, Holiday Inn, Morgantown

May 7 - "The Right to Life -- The Right to Death," (sponsored by the WVU Center for Health Ethics and Law and the West Virginia Network of Ethics Committees)

May 14-15 - "Perioperative Transfusion Medicine," (sponsored by WVU Dept. of Anesthesiology and the West Virginia State Society of Anesthesiologists), White Sulphur Springs

Raleigh County Medical Society - Beckley

April 24 - "Concerns in the Treatment of the Elderly Arthritic," Howard Levine, M.D., 6:30 p.m., Glade Springs Conference Center

April 27 - "Diagnosis of Hyperlipidemia," Michael J. Lewis, M.D., 6:30 p.m., Black Knight Country Club

April 29 - "Diagnosis of Depressive Illness and Aspects of Treatment With Serotonin Reuptake Inhibitors," Sidney C. Lerfald, M.D., 7:30 p.m., Black Knight Country Club

May 5 - "The Treatment of Migraine Headaches," Josiah K. Lilly, M.D., 6:30 p.m., Black Knight Country Club

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Fairmont ★ Fairmont Clinic, April 21, 1 p.m., "The Role of the P.A. in Managing Aging Patients," Lori Stahara, M.D

Fairmont ★ Fairmont General Hospital, May 4, 7:30 p.m., "Lyme Disease," Rashida Khakoo, M.D.

★ Fairmont Clinic, May 19, 1 p.m., TBA

Man ☐ Man Appalachian Regional Hospital, April 20, 7 p.m., "Domestic Violence," Ralph Smith, M.D.

New Martinsville ★ Wetzel County Hospital, May 13, 11:30 a.m., "AIDS," Robert W. Farr, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, April 28, 7 a.m., "ARDS, Shock Lung," Harakh Dedia, M.D.

★ Camden-Clark Memorial Hospital, May 5, 7 a.m., "Prevention in Medical Practice," R. John Pearson, M.D.

★ Camden-Clark Memorial Hospital, May 12, 7 a.m., "Tumors in Children," A. Kim Ritchey, M.D.

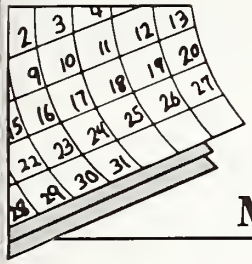
Philippi ★ Broaddus Hospital, May 13, 7 p.m., "How Do Rural Folk Differ From City Folk in Their Health Care Needs," R. John Pearson, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, April 22, noon, "Surgical Complications of Acute MI," Rakesh Wahi, M.D.

Spencer ☐ Roane General Hospital, April 30, 12:30 p.m., TBA

White Sulphur Springs ★ Greenbrier Clinic, April 26, 4 p.m., TBA

Williamson ☐ Williamson Appalachian Regional Hospital, April 22, 5:30 p.m., "Pediatric Transport Concept," Pediatric Transport Team



Medical Meetings

April

22-25—46th Annual National Spring Meeting of the West Virginia Academy of Ophthalmology, White Sulphur Springs

23—Thrombolysis: It's Role in Peripheral Arterial and Venous Disorders, Eastern Virginia Medical School (sponsor), Norfolk, Va.

23-24—Obstetric and Gynecological Ultrasound in Clinical Practice: Reflections and Resolutions, Ohio State University (sponsor), Columbus

25-28—American Group Practice Association, Washington, D.C.

25-29—Professional Practice in Clinical Chemistry: A Review, George Washington University Medical Center (sponsor), Arlington, Va.

25-May 1—American Academy of Neurology, New York City

26-30—American College of Occupational and Environmental Medicine, Atlanta

28-30—Society for General Internal Medicine, Arlington, Va.

28-May 2—Association for Hospital Medical Education, Tucson, Ariz.

28-May 2—Mid-America Orthopaedic Association, Hilton Head Island, S.C.

29-May 1—Annual Spring Meeting of the West Virginia Chapter of the American College of Surgeons, White Sulphur Springs

29-May 2—Clinical Electrocardiography: Basic Concepts and Interpretation - 13th Edition, Eastern Virginia Medical School (sponsor), Philadelphia

30-May 2—Pathology of HIV, George Washington University Medical Center (sponsor), Arlington, Va.

May

1—Hypertension: Clinical Management - 1993, Ohio State University, Columbus

1-7—Advances in Family Medicine, University of Cincinnati (sponsor), Cincinnati

3-5—American Trauma Society, Upper Marlboro, Md.

3-7—American Pediatric Association, Washington, D.C.

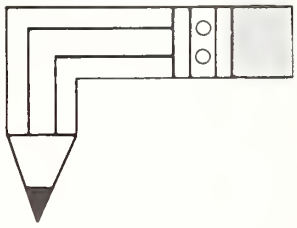
6-9—Intense Orthopedic and Sports Medicine MRI Weekend Review, MRI Education Foundation, Inc. (sponsor), Cincinnati

6-9—Practical Dermatology for the Primary Care Physician - 19th Edition, Eastern Virginia Medical School (sponsor), Pentagon City, Va.

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Mountain Man

Night shades and colors shine on trees up th' hollows
Spreading white light in the hills, reveals,
The coal miner as he goes home in soiled clothes
His face unprepared and covered with black beard.

Looking little at other faces, walking with certain paces,
He's meeting his family's obligations -- no strange machinations.
Seeming unfriendly at home and away simultaneously
Warming only in stages, he's bent on earning wages.

The sunlight's only fitting in the hills, clouds permitting.
The miner's life is spent in bed by day, six days anyway;
Plainly, by his scowl, he works the hootowl.
He sees the women are folk who send the men to work in yoke.

To work through the night and sleep through morning light
He'll wake unnaturally at noon. He's up and eating soon.
He sees the family and packs a bucket -- oh, _ _ _ _ it
Hills and hollows hide openings to the mines, many times.

It's the sort of sordid tale that rhymes can't tell
He was blind to it; or, on some level, knew it,
That men with blackened faces and tarnished souls
Went to work in the earth in holes

Lee L. Neilan, M.D.

Please address your submissions for Poetry Corner to: Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

"ANDERSON, DARNELL, FERGUSON, MARTIN AND A WHOLE BUNCH OF OTHER DOCTORS ... GOOD MORNING."

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Huntley attends national rural health reform meeting

Mary J. Huntley, the director of West Virginia's Office of Community and Rural Health, recently traveled to Arkansas to participate in the "Health Care Reform in Rural Areas" meeting, sponsored by the Robert Wood Johnson Foundation and the Arkansas Department of Health.

Huntley and other selected rural health experts from around the United States assessed proposed reform packages and developed recommendations for consideration by the Clinton administration and Congress.

Worksite wellness program begins for public employees

West Virginia HealthStyles, a public employees wellness program for Charleston area agencies and selected Kanawha County schools, had its official kickoff in March.

Sponsored by the Bureau of Public Health's Division of Health Promotion through a grant from the Public Employees Insurance Agency, West Virginia HealthStyles will help public employees improve their health through preventive screenings, health services, and educational interventions at the worksite. Employees are directly involved in the program planning and implementation. Worksite wellness programs have proven to be cost-effective due to decreased turnover and absenteeism, improved productivity, improved health of the employees, reduced medical costs, improved utilization of the medical system, and decreased occupational injury risk.

For more information about West Virginia HealthStyles, contact Jennifer Valentine at 558-0644.

Heart disease still leading cause of deaths in state, nation

The staff of the Bureau's Division of Health Promotion is encouraging the medical community to cooperate in efforts to lower the occurrence of heart disease among West Virginia residents. Heart disease is currently the leading cause of death in both the state and the nation.

According to the 1991 West Virginia Vital Statistics report, the rate of death due to heart disease in West Virginia is 18% above the national average. During 1991, the age-adjusted rate of deaths due to heart disease was 334.3 for the state and 283.3 for the nation.

The impact of heart disease in West Virginia goes far beyond loss of life. Affected individuals and their families often face psychological stress, loss of employment, lost work time and income, pain and suffering, and high medical bills. To prevent these difficulties, the medical community must encourage individuals to reduce their risk of heart disease by maintaining a regular physical activity program, practicing healthy eating habits, and not smoking.

In an effort to help individuals adopt these healthy lifestyles, the Division of Health Promotion has developed active coalitions in the areas of tobacco prevention, physical activity and nutrition. The staff also provides technical assistance on community-based health promotion and disease prevention strategies.

For more details about heart disease prevention, contact J. T. Morris at 558-0644.

Bureau continues to track infectious medical waste

From the Bureau's preliminary statistics, figures indicate that the over 7,000 generators of infectious medical waste in West Virginia are producing an estimated one million pounds per month. Of this waste, 78% is from large quantity generators, while the remaining 22% comes from small quantity generators (those that generate 50 pounds or less in a one-month period).

Approximately 45% of the infectious medical waste in the state is treated on site, 99% of which is treated by incineration and 1% by steam. The remaining 55% is transported to out-of-state treatment facilities, and this amount is expected to increase when the Environmental Protection Agency promulgates the incineration rules mandated by the Clean Air Act of 1990. The increased requirements for incinerators, imposed by this rule, are expected to eliminate incineration for all but the larger facilities.

Several alternative treatment methods, other than incineration and steam, are beginning to gain acceptance nationwide. Some of these alternatives are designed to treat only sharps and are conducive to the individual practice, while others are designed to treat the many hundred pounds per hour that would be generated in hospitals. These technologies could be employed in the near future to reduce our dependence on out-of-state treatment facilities.

The Infectious Medical Waste Program is continuing to receive applications for permits from those facilities converting to large quantity generators and some other companies who realized they were not in compliance with the rule.

For more questions about a facility's status, contact Joe Wyatt at 1-800-922-1255.

April is National Breastfeeding Month

healthy mothers, healthy babies™

BEST START
West Virginia

CONSULTATION REGARDING PHYSICIAN'S LEGAL ISSUES, INCLUDING:

LICENSING, MALPRACTICE, RISK MANAGEMENT, ESTATE PLANNING, WILLS, TRUSTS, BUSINESS & TAX LAW

DR. RICHARD D. LINDSAY
Practicing Physician & Attorney

GREG R. LORD
Attorney At Law
Master of Laws in Taxation

344-5155 or 1-800-851-2386

405 Capitol Street Suite 309 Charleston, West Virginia 25301

Your CPA: Making Taxes Less Taxing

Question: The evening news just called, saying they'd like to see your tax return. Your first impulse is to call:

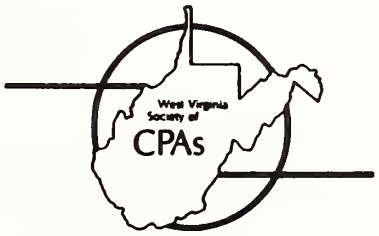
- ☐ a. An arsonist.
- ☐ b. Your "significant other."
- ☐ c. Your guru.
- ☐ d. Your mommy.
- ☑ e. Your CPA!

Answer: Give yourself two points if you chose your CPA. Your Certified Public Accountant has the most current knowledge of individual and corporate tax planning opportunities and the requirements of tax law. This means they can use their knowledge to reduce your year-end tax liability and your tax burden.

Whether your CPA is a company employee or an outside consultant, this professional can provide management advisory services, accounting, auditing, financial and tax planning. Members of The West Virginia Society of CPAs bring high professional standards to their work, backed by the resources of a 1,600-member professional association.

If you want information on reducing your tax liability, write for a free brochure to The West Virginia Society of CPAs, Department A, P.O. Box 1142, Charleston, WV 25324.

When you want to make a sound investment in your business, use a CPA.



WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center, Communications Division, Morgantown.

WVUH trauma patient survival rate at 96 percent for 1992

Ninety-six percent of the 1,575 patients who were treated at the John Michael Moore Trauma Center at WVU Hospitals in 1992 survived and were discharged, and 70 percent of these patients had major injuries.

"An overall survival rate of 96 percent is exceptional, compared to other trauma centers of this size," Gregory A. Timberlake, M.D., F.A.C.S., director of the trauma center said. "This is a source of great pride to all of us. It reflects on the hard work and dedication of the entire trauma team – faculty and resident physicians, nurses, other health care providers and administrative staff," he added.

The center at WVUH is the only Level 1 trauma center in northern West Virginia. A third of the trauma patients were transfers from other hospitals.

According to Dr. Timberlake, trauma accounted for only a small fraction of the nearly 40,000 emergency department patients treated at WVUH in 1992. Motor vehicle crashes were the most common cause of trauma hospitalization and more than 80 percent of these victims admitted to WVUH were not wearing seat belts. Two of every three patients were males, and 41 percent were under age 25.

Symposium to focus on ethics issues

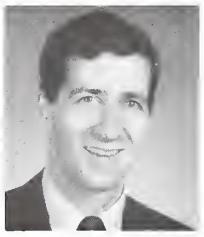
Should physicians be allowed to assist their patients in dying? This question will be among the subjects highlighted during the Sixth Annual Symposium of the West Virginia Network of Ethics Committees, May 7, at the WVU Health Sciences Center.

"The Right to Life – The Right to Death" will focus on issues associated with abortion, euthanasia, care of the dying, physician-assisted suicide, and withholding and withdrawing life-sustaining treatment.

The keynote address, "An Update on Withholding and Withdrawing Life-Sustaining Treatment – Ethics and the Law" will be delivered by the Rev. John J. Paris, S.J., Ph.D., a nationally known bioethicist. Dr. Paris was a consultant to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. He has been an expert witness in several precedent-setting "right to die" cases.

For more details, call the WVU Center for Health Ethics and Law at (304) 293-7618.

Weinstein publishes first book dealing with dental ethics



Weinstein

Bruce Weinstein, Ph.D., associate director of the WVU Center for Health Ethics and Law and an assistant professor in community medicine, has written the first book focusing on the ethics of dental practice.

The book, "Dental Ethics," was published by Lea & Febiger of Philadelphia and London, and is expected to be used as a text in dental and dental hygiene classes, as well as a reference tool for practitioners.

Tarry featured speaker at Urological Society's annual meeting

Tarry

Dr. William Tarry, associate professor of urology, gave two lectures at the West Virginia Urological Society's annual meeting, March 26-28 in Huntington.

Dr. Tarry's two presentations were entitled "Pediatric Laparoscopic Surgery" and "Wet Lab at Conference Center."

Swinker re-appointed to AAFP committee

Swinker

Marian L. Swinker, M.D., M.P.H., associate professor of family medicine, has been re-appointed to another year's term on the Committee on Women in Family Medicine of the American Academy of Family Physicians (AAFP).

Dr. Swinker was first appointed in 1992 to this committee, which is dedicated to issues involving members of the AAFP, as well as women in organized medicine.

Ramadan discusses unilateral vocal cord paralysis treatment

Dr. Hassan H. Ramadan, assistant professor of otolaryngology, was a guest lecturer at the American Laryngological Rhinological and Otological Society Section Meeting, January 30-31, in New York City.

At the meeting, Dr. Ramadan discussed Thyroplasty I or medialization laryngoplasty, a recent advancement for the treatment of unilateral vocal cord paralysis that doesn't scar the vocal cords, like teflon injection sometimes can. Dr. Ramadan described the results he has had after performing this new procedure on 15 patients over the last two years.

Sex education video program available

An innovative videotape program, "Let's Talk Sense About Sex," has been produced by the WVU Extension Service with assistance from other WVU units to help families promote healthy sexual development and encourage the postponement of sexual activity by young people.

The award-winning program was funded by the Office of Adolescent Pregnancy Programs, U.S. Department of Health and Human Services, and can be obtained by calling (304) 293-2694.

Perioperative Transfusion Medicine

May 14-15, 1993

WVU Health Sciences Center
Morgantown, West Virginia

Topics include:

- Update on Transfusion-Transmitted Infections
- Preoperative Autologous Blood Donation
- Perioperative Autologous Blood Salvage
- Preoperative Evaluation of Hemostasis
- The Transfusion Trigger for Perioperative Red Blood Cell Transfusion
- Leukocyte Depletion of Cellular Blood Components in Perioperative Hemotherapy
- Pharmacologic Adjuncts to Perioperative Hemotherapy

To register, contact: The Office of CME at 1-800-WVA-MARS or 304-293-3937

Sponsored by: WVU School of Medicine Office of Continuing Medical Education, WVU Department of Pathology, and the Johnstown Region - American Red Cross Blood Services

RUN A SPECIAL PRACTICE.

Today's Air Force has special opportunities for qualified physicians and physician specialists. To pursue medical excellence without the overhead of a private practice, talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay each year that are part of a medical career with the Air Force. Discover how special an Air Force practice can be. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

Zill conducting study on neuronal mechanisms of balance

Photo by Rick Haye

Marshall laboratory technician Faith Frazier focuses a computerized video camera that helps researchers learn precisely how insects use feedback from their legs to adapt to uneven or unstable surfaces. The Marshall findings will help scientists at Case Western Reserve University "teach" these walking skills to robots with insect-like legs such as the one shown in the photo below.

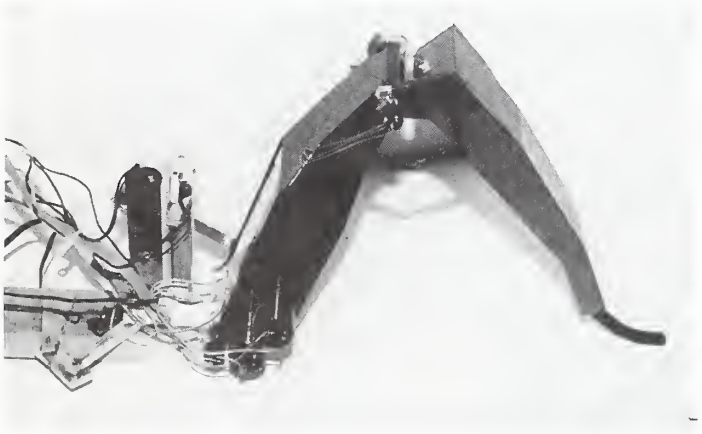


Photo courtesy of Case Western Reserve University

Dr. Sasha Zill, an associate professor of anatomy and cell biology, has received a $300,000 Office of Naval Research grant to study neuronal mechanisms of balance and locomotion in insects. The results will help program legged robots that "walk" independently, as well as provide insight into diseases such as multiple sclerosis.

The project takes a pragmatic approach to the concept of artificial intelligence: that the ability to "think" like a human has little to do with the ability to move independently — a talent cockroaches developed millenia ago.

Dr. Zill and his team are collaborating with researchers at Case Western Reserve, the University of California at Berkeley and the Massachusetts Institute of Technology. Together they expect to learn how the primitive nervous systems of insects handle movement, then translate those findings into sophisticated programming for multi-legged robots.

The Case Western team already has developed a two-foot-long computerized "cockroach" controlled by a network that models the insect's nervous system. Programmed by computer scientist Randall Beer and built by robotics experts Roger Quinn and Kenneth Espenschied, it looks more like a row of skateboards than an insect — but it walks. The next step is to teach its more elaborate descendants how to react to changes in terrain.

"If you close your eyes and move your hand, your brain still senses exactly where your hand is in space because of receptors in your joints and muscles that constantly tell the brain where they are," Dr. Zill explained. "Insects have these sense organs, too, that encode information about leg position and movements, then relay that information to the brain. Marshall's role in the Navy project will be to examine how insects use this information to adapt their walking patterns on surfaces that are uneven and unstable," he added.

For several years, Dr. Zill and his research team have studied the workings of these receptors. A state-of-the-art video computer system now allows them to match up the receptors' signals with the specific joint angles and leg positions that prompted them.

The Marshall group, which also includes graduate student Gregory Larsen and lab technician Faith Frazier, will pass on its findings to Case Western scientists who will try to create similar sensors for robot legs. Dr. Zill said these robots will be completely self-contained, unlike their distantly related eight-legged cousin whose Antarctic volcano exploration was abandoned a few months ago when its remote-control cable was cut.

"The robots we're working on will have their own onboard computers," he said. "Using the NASA example, the robots could be sent to the moon with the general command to find rock samples. Their computers would allow them to independently perform walks, searches and digs; to analyze the samples; and to transmit the data back to Earth. Human lives would never be at risk."

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

HealthCare Financial Services

A Division of Strategic Health Services, Inc.

1204 Kanawha Boulevard, East
Post Office Box 3882
Charleston, West Virginia 25338

"Your Medical Collection Service"

Affiliated with Charleston Area Medical Center, Inc.

We are proud to be the largest and most sophisticated collection service in West Virginia. Our emphasis is service and client image and our services are marketed exclusively to health care providers. Please call today for a review of our services and what we can do to assist your cash flow position.

J. Bruce Dunlap
Director of Operations

Thomas Harris
Marketing Manager

304-345-4371

In WV 1-800-369-4371 **FAX 304-345-4323**

Medical Student News

Help us better serve you!

Dear Fellow Medical Students:

On this page in February, I had the great pleasure of addressing you for the first time as your newly-elected president. This month I would like to share with you some of the preliminary plans we have made to guide the WVSMA Medical Student Section through another year of continued growth.

In May, the WVSMA-MSS Executive Council will meet at the WVSMA office in Charleston to set goals and discuss plans for participating in the WVSMA's Annual Meeting at The Greenbrier in August. Vice President David Artz will be reporting on the proposal he has been working on to change the bylaws so the scope of the MSS membership can be increased. Myra Wilkerson, secretary/treasurer, plans to describe her involvement with the Doc-For-A-Day program at the West Virginia State Legislature and how we can become more active with this project. I will be explaining the details of the fall membership drive and obtaining suggestions for ways to assist and support the individual campuses with their recruitment efforts. In addition, the MSS Executive Council members will have the valuable opportunity of meeting with the members of the WVSMA Executive Committee.

So how does all of this affect you? Myra, David, and I are counting on you to talk with your campus officers about the issues that concern you so they can discuss them at this meeting. Even though interaction from members continues to increase, there is still a great need for much more involvement. It is essential for us to have input from as many members as possible, so we can better serve the interests of **ALL** of our members. We hope that many more members will take an active role this year and let us know their suggestions and ideas.

In addition to sharing your ideas with one of us or your campus officers, I would like for members to submit articles and ideas for this page in the *Journal*. I want to try to make this page an opportunity to share information about the activities of all three campus societies. If you have information or an article to share, please mail it to me at The Belford, 612 Eleventh Avenue, Huntington, WV 25701.

REMEMBER THE WVSMA-MSS IS YOU! TAKE AN ACTIVE PART!

Mark S. Wright
WVSMA-MSS President

EENT Seminar for Primary Care Physicians 1993 Update

Topics Include:
Sinusitis
Ophthalmic Emergencies
Common Pediatric EENT Conditions

DATE
Saturday, May 22, 1993

LOCATION
Charleston Marriott

CREDIT
4.5 Hours AAFP
4.5 Hours CME Credit, Category I

SPONSOR
The Eye and Ear Clinic of Charleston, Inc.

CO-SPONSOR
Department of Family Medicine
WVU Health Sciences Center
Charleston Division
Charleston Area Medical Center

For Registration Information, Call:
353-0324
Toll-Free in WV:
1-800-642-3049, ext. 324

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

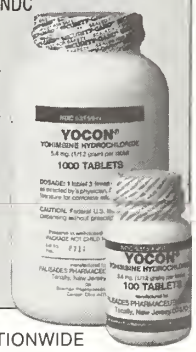
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Obituaries

Russell Arthur Salton Jr., M.D.

Dr. Russell Arthur Salton Jr., 71, died December 20 at his home in Williamson.

A native of Williamson, Dr. Salton received his medical degree at the University of Virginia School of Medicine in Charlottesville in 1942. He served his internship and residency there and remained in Charlottesville for 13 years.

Dr. Salton served three years with the U.S. Air Corps and was chief surgeon for two years at the Suisun Air Force Base (now Edwards AFB) in California. Despite an opportunity to remain in the Air Force with a promotion to major, circumstances brought him back to Williamson in 1949 and he assumed the operation of Williamson Memorial Hospital, which his father, the late Dr. R. A. Salton Sr., had help to found. He operated the hospital with Dr. Woodrow W. Scott, and then later with Dr. Robert J. Tchou.

In 1978, Dr. Salton sold the hospital to Hospital Management Associates and retained his offices in the lower area of the facility and served as president and medical director of the R. A. Salton Senior Clinic, Inc., named in honor of his father. He remained on frequent call and was in charge of the Outpatient Department of the hospital under the HMA system before retiring.

During his years in medical practice and since his retirement a few years ago, Dr. Salton was involved with the operations of the Mingo County Airport and the Mingo County Cancer Society (independent). He headed the airport authority by the appointment of the Mingo County Commission and served continuously as president of the Mingo County Cancer Society.

Survivors include his sons, Dr. R. A. Salton III and Robert L. Salton, both of Charlotte, N.C.; daughters, Mrs. Frances Salton Neal of Shelbyville, Ky., Mrs. Elizabeth Salton Byard of Dothan, Ala., and Mrs. Mary Jane Salton Walters of Mooreville, N.C.; sister, Ms. Virginia Salton of Williamson; and nine grandchildren.

County Society

McDowell

At the society's March meeting, Zakaria W. Maniya, M.D., was accepted unanimously as a new member.

In other new business, Dr. C. E. Michaelis presented a request for funds to help pay the expenses for all-night graduation parties for the three county high schools. The members voted to donate $50 to each school.

New delegates to the WVSMA's House of Delegates were also appointed at the meeting. Dr. C. Anderson was named as the delegate and Dr. C. Flores was selected as the alternate delegate.

Davis & Davis Accounting Services

602 Tennessee Avenue • Charleston, WV 25302
• 304-343-4656 • 800-281-4572 • FAX 304-343-4657

Davis and Davis Accounting provides efficient electronic medical billing to help you receive faster reimbursement. We can bill insurance companies daily, weekly, monthly and/or on demand. As a result of prompt billing, the turnaround time on your reimbursement claims can be reduced by as much as 30 days.

We provide:

- filing of all primary and secondary insurance claims
- patient billing - as lump sum or budget payments
- collections - open line posting, follow up letter on late payments, problem accounts (three letters and turn over for collection)

Billing System equipped with:

- line error checking
- account aging
- cycle billing capablilities
- open line posting
- custom reports tailored to you individual practice

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to The Journal.

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

THE WEST VIRGINIA
MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U. S. A.; $60 in foreign countries; $3 per single copy. Address all communications to The West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the West Virginia Medical Journal will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article
Confessions of a rookie 186

Scientific Newsfront
Herpes esophagitis in immunocompetent adults: Report of two cases and review of the literature
Sandra Y. Elliott, M.D.; Fred T. Kerns, M.D.; and Lynn W. Kitchen, M.D. 188

Simplified method of evaluating dysfunction in St. Jude medical prosthetic heart valves
Mark J. Hermacinski, M.D.; and L. Gonzalez-Lavin, M.D., F.A.C.S., F.A.C.C., F.A.C.C.P., F.A.A.P. . . . 191

An "above ground" pool hazard
Harvey D. Reisenweber, M.D. 194

President's Page
The Medicaid gridlock 196

Editorial
Frank J. Holroyd, M.D., R.I.P. 199

Guest Editorial
Deeefense 200

Our Readers Speak 200

Special Departments
General News 204
Continuing Medical Education 208
Medical Meetings/Poetry Corner 209
Bureau of Public Health News 210
WVU Health Sciences Center News 212
MU School of Medicine News 214
Auxiliary News 216
New Members/WESPAC Members 218
Obituary 219
Classified 221
May Advertisers 222

Front Cover
Rose dragon head in bloom at Twin Falls State Park in Mullens, W.Va. Photo courtesy of *Scott Durham* of Pineville, W.Va.

Confessions of a rookie

My first AMA meeting held many surprises, and I came away with a newfound respect.

BOB Q. LANIER, M.D.
Allergist, Fort Worth, Texas; and Executive Director of the Academy of Radio and Television Health Communicators

Editor's Note: *This article is reprinted with the permission of the Cortlandt Forum, 500 Executive Blvd., Ossining, NY 10562. We are publishing it this month in recognition of the AMA's Annual Meeting which will be held June 13-17 in Chicago.*

No one has been more critical of the "good ol' boys" of the American Medical Association than I. In my frustration with the halting movement of medicine in times of crisis, I have used such terms as dinosaurial, archaic, unwieldy, constipated, and impotent, and these in some of my more generous moments. One *Cortlandt Forum* reader admonished me with a quote from Twain: "Get your facts first; then you can distort them as much as you please."

So when a specialty society asked me to fill an AMA alternate-delegate slot, I considered it briefly and then protested, "I'm only 47 years old, and I still think for myself." The response was, "It's okay, there are plenty of activities for youngsters now. Besides, the meeting is in Las Vegas, so you can think or say whatever you want!"

The burden of guilt was heavy as I stepped out of a cab at the Las Vegas Hilton for my first meeting. Furtive glances revealed no angry doctors brandishing copies of past editorials. But 2,000 doctors are hard to hide in one hotel, and I began to pick them out by a process of elimination. Doctors generally do not smoke cigarettes or wear belt buckles the size of small hubcaps. Doctors have recent haircuts and wear huge nametags with three-inch ribbons and lots of little doodads and stickers.

The most striking thing about an AMA meeting is the volume of paper used. Whole forests are logged for a single meeting. The paper generated is then recycled into hernias for those carrying it around. The most treasured item at the convention is a thick piece of sturdy fabric with a handle at each end. At home, I use one to carry in logs for the fireplace. At AMA meetings, it's used to carry paper.

I felt somewhat intrigued as I walked into my first AMA meeting with my log carrier full of resolutions and positions. The meeting room was enormous. There were hundreds of huge flags and gigantic banners. The University of Nevada, Las Vegas, marching band was playing militant march tunes at rock-concert volume to pump up the audience. Thousands of people were milling around, but I soon began to pick up patterns. Each delegate wore a state jacket in the appropriate colors. As people took their seats in designated areas, the room began to look like a football stadium with a huge card section.

A closer look revealed that the good ol' boy ranks have been invaded by quite a number of women and young people. Students have their representatives, as do residents and the "young physician" -- someone who has completed his residency but is not old enough to qualify for full good ol' boy status. That comes not at 65, as I had thought, but at 40! With a rush, the realization came to me . . . *I* am a good ol' boy.

With more than a few crow feathers sticking to my lips, I sat through exhausting and often passionate debates. I always thought AMA position papers came out of sedate committees that rubber-stamped staff recommendations, but it's just not so. The good ol' boys don't mind taking off their gloves. In fact, the process I always assumed to be dictatorial is, in fact, excessively democratic. More than once I felt the urge to take my log carrier and rap some microphone hog in the temple.

I expect some of you will think that I have sold out to the AMA. It's not true; I just have more facts to distort. Despite my earlier views, good ol' boys come in either sex and are of every race, creed, color and age. They can be identified by their response to the simple question: "Do you like these meetings?" A "yes," no matter how qualified, is diagnostic. A good ol' boy will spend most of his or her professional life as a medical politician; there are no term limitations. Will Rogers once said: "The country's too important to be left to politicians." So is medicine. Thank goodness for the many doctors who weather the bureaucracy and even become part of it without being seduced. Their careers must be shorter, but perhaps they contribute more.

I once thought the best thing we could do for this country would be to send all U.S. citizens to some other country for a month so they would have some frame of reference before they complained too loudly. Maybe we should send every doctor to an AMA meeting. It would make writing that yearly blockbuster check a lot less painful and perhaps give us insight for reasonable criticism.

Years From Now, Will You Still Be Protected For The Procedures You Perform Today?

Every decision a doctor makes carries a risk. And you never can tell how many years from now a claim could arise.

That's why it's vital to be insured by a company that'll be around to protect you and your practice years into the future.

CNA has been protecting doctors against malpractice claims for over 30 continuous years. A record which demonstrates our dedication to providing continual coverage even in uncertain times.

For more information about medical malpractice insurance from the CNA Insurance Companies, contact your local agent or:

McDonough Caperton Insurance Group
One Hillcrest Dr. East
P.O. Box 3186
Charleston, WV 25332-3186
(304) 346-0611

WVSMA
P.O. Box 4106
Charleston, WV 25364
(304) 925-0342

We're there when you need us most.

The WVSMA CNA Physicians Protection Program is underwritten by Continental Casualty Company, one of the CNA Insurance Companies/CNA Plaza/Chicago, IL 60685.

CNA

For All the Commitments You Make®

Herpes esophagitis in immunocompetent adults: Report of two cases and review of the literature

SANDRA Y. ELLIOTT, M.D.
Marshall University School of Medicine and Veterans Administration Medical Center, Huntington

FRED T. KERNS, M.D.
West Virginia University School of Medicine, Charleston Division, Charleston

LYNN W. KITCHEN, M.D.
Marshall University School of Medicine and Veterans Administration Medical Center, Huntington

Abstract

This article describes two cases of esophagitis in immunocompetent adults associated with herpes simplex virus type 1 (HSV-1) infection. One case presented with pharyngitis and the other with whitlow. A review of the literature revealed 21 other cases in immunocompetent adults; and, of these 21 patients, odynophagia was noted in 19, nine experienced fever, and oral lesions were found in five of these individuals. Barium swallow was positive in 8 of 20 patients tested, whereas esophagoscopy showed ulcers in 17 of the 20 cases. Specimens obtained during esophagoscopy revealed viral inclusions in 13 of the 20 patients tested, and viral cultures were positive in 11 of the 15 patients tested. Although upper gastrointestinal hemorrhage occurred in one patient, symptoms generally resolved within a few weeks whether or not acyclovir was administered.

Introduction

The majority of cases of herpes esophagitis have been reported in patients with known malignancy, immunosuppression, or non-malignant debilitating diseases (1,2); and antemortem diagnosis was infrequent prior to the AIDS epidemic. Recently, it has been more frequently recognized or suspected in immunocompetent individuals as well.

This article reports our findings concerning one case of culture-proven HSV-1 esophagitis in a previously healthy adult and a probable second case (based on clinical findings); it also summarizes information available from previous publications focusing on the presentation, diagnosis, and outcome of this uncommon disease.

First case report

A single heterosexual white male student, age 19, who was taking no routine medications and had an unremarkable medical history, came to the Outpatient Department at Charleston Area Medical Center with fever, sore throat, and generalized malaise of three days duration. Throat swab test for streptococcal antigen, blood counts, routine serum chemistries and monospot test were all within normal limits.

This patient was discharged home on anti-pyretics for symptomatic relief after a throat culture was taken, but returned to the hospital 48 hours later with worsening symptoms, including severe odynophagia, mid-epigastric pain, and difficulty in swallowing both liquids and solids. He denied any history of fever blisters, upper respiratory symptoms, genital or skin lesions, nausea, vomiting, or previous gastrointestinal complaints. He also denied any recent weight loss, trauma, surgical procedures, or endoscopy. His only risk factor for human immunodeficiency virus (HIV) infection was unprotected heterosexual intercourse with multiple partners over the past year.

Physical examination revealed a well-developed, well-nourished white male complaining of epigastric pain and weakness. Significant findings included a temperature of 37.3°C; an orthostatic drop in blood pressure; severely erythematous posterior pharynx with multiple pustules and ulcerations; multiple soft, non-tender mobile cervical lymph nodes approximately 0.5 cms. in diameter; and mild epigastric tenderness that was noted on abdominal examination.

Laboratory tests including urinalysis, throat culture, electrocardiogram, and chest roentgenogram were within normal limits, as were repeat blood counts, bilirubin, alkaline phosphatase, transaminases, and monospot. Esophagoscopy revealed diffuse ulcerative changes in the proximal esophagus (reaching confluence in the distal esophagus); the stomach was unremarkable.

The ulcerative lesions were biopsied and brushed for fungal and viral cultures and cytological examination. Pathology showed acute and chronic inflammation without viral inclusions or pseudohyphae. Methenamine silver stains were negative for fungus. Viral cultures of the esophageal ulcers were positive for HSV-1 (as were oropharyngeal secretions). Oropharyngeal swab was also positive for HSV-1 antigens by direct fluorescent antibody technique. His serum tested positive for antibody to HSV-1 (by indirect immunofluorescence; 1:2560 at the time of admission, and 1:5120 four weeks later). Delayed hypersensitivity was tested at the time of diagnosis with positive skin test for Candida and mumps and negative tuberculin test. Test for serum antibody to human immunodeficiency virus was negative.

Following endoscopy, the patient was treated with a four-day course of intravenous acyclovir (300 mgs. every eight hours); marked improvement was noted within 48 hours. Four days later, the patient was asymptomatic and was discharged home on six additional days of oral acyclovir (200 mgs. five times per day). He remains well 10 months following his illness without recurrence of esophageal symptoms or oropharyngeal herpes.

Second case report

A previously healthy married female nurse, age 37, presented to the Charleston Area Medical Center Emergency Department with a one-month history of nausea, vomiting, epigastric pain, and a 4.5-kg. weight

loss. Four days prior to admission, she had noted small vesicular lesions on the fourth finger of her left hand.

On the day this patient was admitted to the hospital, she developed several mouth ulcerations. She denied any history of fever, chills, cold sores, genital lesions, upper respiratory symptoms, trauma, surgical procedures, or endoscopy. She also denied needlestick injuries and any risk factors for HIV (other than routine exposure to body secretions pertinent to her employment as an emergency room nurse).

Past medical history was unremarkable with the exception of recent diagnosis of bipolar mood disorder treated with lithium. Other medications included ranitidine and sucralfate (since onset of gastrointestinal symptoms), and all three drugs had been ingested orally.

Physical examination revealed a well-developed, well-nourished white female complaining of epigastric pain. Significant physical findings included a temperature of 38°C; many clusters of pustules on the lower lip; an erythematous oropharynx with multiple vesicular lesions in the posterior pharynx; and a pustular lesion 0.5 cms. in diameter with surrounding erythema on the fourth finger of the left hand.

Routine laboratory parameters (including blood count, bilirubin, alkaline phosphatase, transaminases, and urinalysis) were within normal limits as were electrocardiogram and chest roentgenography. Serum tested negative for antibody to HIV. Esophagogastroduodenoscopy revealed multiple oral and pharyngeal ulcerations from the mid-esophagus to the gastroesophageal junction; the stomach and duodenum were unremarkable. These ulcerative lesions were biopsied for fungal and viral cultures and histopathological examination. Pathology revealed ulcerated and inflamed mucosa without viral inclusions or pseudohyphae. Viral cultures of the oropharynx and finger lesions grew HSV-1. Unfortunately, the viral cultures obtained from esophagogastroduodenoscopy were not analyzed because of improper handling. HSV serum antibody level and skin testing for delayed hypersensitivity were not done.

Following endoscopy, the patient was treated with a four-day course of intravenous acyclovir (300 mgs. every eight hours), with gradual improvement in symptoms. She was subsequently discharged home on oral acyclovir (200 mgs. five times daily) for 10 additional days and remains well four months following her illness.

Table 1. Characteristics of herpes simplex esophagitis in 21 previously reported cases occurring in immunocompetent hosts.

Clinical features:

Age: Range: 17-68 years; Mean: 30.3 years; Median: 24 years

Sex: 6 female, 15 male

Course: Range: 6-42 days; Mean: 17.5 days (based on 11 patients)

Symptoms and Signs:

Odynophagia: 19/21

Dysphagia: 7/21

Fever: 9/21

Herpetic lesions (oropharyngeal) at time of presentation: 5/21

Recent upper respiratory infection: 4/21

Recent sore throat: 2/21

Previous esophageal symptoms: 3/21

Herpetic lesions occurring after admission on lips or extremities: 3/21

Diagnostic features:

Abnormal barium swallow: 8/20

Ulcers on endoscopy: 17/20

Inclusion bodies: 13/20

Positive viral cultures of esophageal ulcer: 11/15

4-fold increase in HSV-1 antibody level found in 3/11 patients tested for antibody levels (all 11 patients had detectable serum antibody level to herpesvirus at some point during their illness)

Other pathogens from esophageal culture: 2/20

Discussion

In addition to our two cases, a search of English-language literature from 1966 through January 1992 revealed 21 cases of herpetic esophagitis in immunocompetent adults (3,4,5,6,7,8,9,10,11,12,13); the data is summarized in Table 1. Patients with known diabetes mellitus or corticosteroid use were excluded, as were patients with fulminant herpes hepatitis but no esophageal symptoms (14,15,16).

Nineteen of the 21 patients reported painful swallowing (odynophagia), and of the two other patients who denied painful swallowing, one had a foreign body sensation in the chest and the other had chest pain. However, less than half of the 21 patients reported non-painful difficulty in swallowing (dysphagia), fever, or oral vesicles at the time of presentation. Three patients had noted recent oral lesions in a family member living in the same residence; two patients were noted to have oral lesions after admission; and two patients developed vesicular extremity lesions culture-positive for HSV-1 three days after admission. Three patients had incompetent lower esophageal sphincter and consequent gastroesophageal reflux diagnosed before admission or during admission. We drew no conclusions from the data as to whether or not herpes esophagitis is related to high numbers of sexual partners and/or specific sexual practices.

Endoscopy revealed ulcers in 17 of 20 of the reviewed cases. Although herpetic lesions have a characteristic endoscopic appearance, they may be difficult to distinguish from ulcers caused by other viruses or C. albicans. Herpetic lesions typically appear as multiple punched-out ulcers covered by fibrinous material, with or without vesicles. Diagnosis of herpes esophagitis in early case reports was frequently based on typical clinical presentation and pathologic findings on endoscopic biopsy or brushing (acute inflammation with intranuclear inclusion bodies and multinucleated giant cells, as noted in 13/20 patients tested in our review) (5,17).

More recent reports indicate that herpes viral cultures during prompt endoscopic biopsy have been helpful in diagnosis (11 of 15 patients in our review) (18). Diagnosis of herpes esophagitis in our case review series was based on positive esophageal culture and/or inclusion bodies (19 cases) or esophageal ulcers plus odynophagia and "herpetic" lip lesions (two cases). The endoscopic specimens from one elderly female patient with a prior history of oral candidiasis were culture-positive for C. albicans. A gram-stain of brushings

of esophageal lesions from another patient indicated "mixed flora" in addition to HSV.

In contrast, barium esophagogram studies do not appear to be helpful in diagnosis, because of low sensitivity and specificity (C. albicans infections, corrosive esophagitis, or gastroesophageal reflux may be followed by similar esophagogram changes) (12). Only eight of the 20 patients who underwent esophagograms in our review demonstrated the characteristic nodular contour of the esophagus with rounded or irregular defects consistent with a possible diagnosis of herpes esophagitis (19).

A four-fold rise in serum antibody to HSV-1 may confirm recent infection with HSV-1, but this information is generally not available at the time of presentation. Of the 21 patients in our review, 11 were tested for serum herpesvirus antibody levels at some point during the course of their disease, and all 11 had detectable antibody at some stage. However, only three patients were noted to have a four-fold rise in serum antibody titers to HSV-1 over several weeks. Furthermore, the increase in serum antibody levels to HSV-1 in the first of the two cases reported in this paper would generally be considered non-significant, and serum antibody levels to HSV-1 were not obtained in the second case presented.

Three of the 21 patients reviewed were treated with acyclovir administered intravenously, and one of these patients was given additional oral acyclovir. Four patients were treated with antacids and cimetidine. Three patients were given oral viscous xylocaine for pain relief. Gastrointestinal bleeding requiring transfusion (as well as antacids and cimetidine) was a problem in one woman. However, this case was unusually complicated because of her age (68 years) and the presence of other diseases (e.g., adenocarcinoma of the colon without distant metastases, and incompetent lower esophageal sphincter with significant motility disorder of the lower end of the esophagus). She was included in this case series because the adenocarcinoma was detected shortly after diagnosis of herpes simplex esophagitis.

All patients recovered without sequelae or recurrence of esophagitis. The mean time from presentation to resolution of symptoms was 17.5 days among 11 of the 21 previously published cases in which the recovery interval was noted.

Although diagnosis of herpes esophagitis in immunocompetent adults is an infrequent occurrence, and HIV testing should be undertaken in such cases (after obtaining informed consent), HIV-negative patients (with no history of opportunistic infections to suggest HIV-negative AIDS) may benefit from physician reassurance that prompt recovery is anticipated and the disease is unlikely to recur. Additional study is needed to confirm the value of acyclovir (and to investigate the advisability of administering pharmaceutical agents to prevent or mitigate upper esophageal hemorrhage) in the treatment of herpes esophagitis in immunocompetent hosts.

References

1. Berg J. Esophageal herpes: a complication of cancer therapy. Cancer 1955;8:731-40.
2. Montgomerie J, Becroft D, Croxson M, Doak P, North J. Herpes-simplex-infection after renal transplantation. Lancet 1969; 2:867-71.
3. Chaudhary M. Herpes simplex esophagitis. Kansas Medicine 1986;87:334-40.
4. DeGaeta L, Levine M, Guglielmi G, Raffensperger E, Laufer I. Herpes esophagitis in an otherwise healthy patient. Am J Roentgenol 1985;144:1205-6.
5. Depew W, Prentice R, Beck I, Blakeman J, Docosta L. Herpes simplex ulcerative esophagitis in a healthy subject. Am J Gastroenterol 1977;68:381-5.
6. Deshmukh M, Shah R, McCallum R. Experience with herpes esophagitis in otherwise healthy patients. Am J Gastroenterol 1984;79:173-6.
7. Desigan G, Schneider R. Herpes simplex esophagitis in healthy subjects. So Med J 1985;78:1135-7.
8. DiPalma J, Brady C. Herpes simplex esophagitis in a non-immunosuppressed host with gastroesophageal reflux. Gastrointest Endosc 1984;30:24-5.
9. Fishbein P, Tuthill R, Kressel H, Friedman H, Snape W. Herpes simplex esophagitis: a cause of upper gastrointestinal bleeding. Digestive Diseases and Sciences 1979;24:540-4.
10. Owensby L, Stammer J. Esophagitis associated with herpes simplex infection in the immunocompetent host. Gastroenterol 1978;74:1305-6.
11. Solammadevi S, Patwardhan R. Herpes esophagitis. Am J Gastroenterol 1982;77:48-50.
12. Springer D, DaCosta L, Beck I. A syndrome of acute self-limiting ulcerative esophagitis in young adults probably due to herpes simplex virus. Digestive Diseases and Sciences 1979;24:535-9.
13. Yacono J. Type 1 herpes simplex esophagitis with candidal esophagitis in an immunocompetent host. NY State J Med 1985; 85:656-8.
14. Brayko C, Kozarek R, Sanowski R, Lanard B. Herpes simplex esophagitis with concomitant esophageal moniliasis. J Clin Gastroenterol 1982;4:351-5.
15. Pazin G. Herpes simplex esophagitis after trigeminal nerve surgery. Gastroenterol 1978;74:741-3.
16. Williams T, Morgan J, Denzler T. Fulminant herpes simplex hepatitis following coronary bypass and postcardiotomy syndrome. Am Heart J 1985;110:679-80.
17. Ng A, Reagan J, Lindner E. The cellular manifestations of primary and recurrent herpes genitalis. Acta Cytol 1970;14:124-9.
18. Klotz D, Silverman L. Herpes virus esophagitis, consistent with herpes simplex, visualized endoscopically. Gastrointest Endosc 1974; 21:71-3.
19. Levine M, Laufer I, Kressel H, Friedman H. Herpes esophagitis. Am J Roentgenol 1981; 136:863-6.

Simplified method of evaluating dysfunction in St. Jude medical prosthetic heart valves

MARK J. HERMACINSKI, M.D.
L. GONZALEZ-LAVIN, M.D., F.A.C.S., F.A.C.C., F.A.C.C.P., F.A.A.P.
Department of Cardiac Surgery, Marshall University School of Medicine, Huntington

Abstract

The St. Jude medical valve is one of the most common heart valve protheses used. More than 450,000 have been implanted. Patients with these prosthetic valves need full anticoagulation and close follow-up for life. Without adequate oral anticoagulation, thrombotic complications may develop. A simple method of evaluating the full range of motion of the valve leaflets can be attained by fluoroscopy. Fluoroscopy is easily available, non-invasive, and diagnostic. This article demonstrates early recognition of valve dysfunction due to thrombosis with fluoroscopy leading to prompt treatment.

Introduction

Mechanical prosthetic valves are the first choice for valve replacement in young patients, and one of the most commonly used is the St. Jude medical valve. A drawback of this prosthetic valve is the need for effective anticoagulation. It is important to maintain close follow-up of these patients because of the possibility of emboli and valve thrombosis.

This report describes the diagnosis and treatment of left atrial thrombosis and prosthetic mitral valve dysfunction. We advocate a simple and effective way of monitoring valve function by fluoroscopy.

Case Report

A 45-year-old man with a past history of rheumatic fever who had mitral stenosis and mitral regurgitation underwent an uneventful mitral valve replacement in February 1992 with a 29 mm. St. Jude medical valve. He came to the hospital again in August 1992, with a two-month history of dyspnea. The history revealed inadequate anticoagulation, with his prothrombin time as low as 14 seconds.

Figure 1. Pre-operative chest X-ray -- diffuse pulmonary edema

This patient's condition continued to deteriorate with increasing shortness of breath, occasional fainting spells, and respiratory distress. He became tachypneic and had rales and wheezes on auscultation. A crisp prosthetic sound without murmurs was revealed during auscultation of his heart. He had bilateral, lower extremity, pitting edema.

Two transthoracic echocardiograms prior to admission showed normal left ventricular function with an apparently normally-functioning prosthetic valve and no significant mitral regurgitation. The medical work-up revealed a prothrombin time of 18 seconds, a hemoglobin of 10 g./100 ml., and a white blood cell count of 14,000 c.mm. A chest X-ray disclosed pulmonary edema (Figure 1). An electrocardiogram revealed atrial fibrillation with a ventricular rate of 110 per minute. Due to rapid clinical deterioration, fluoroscopy was ordered to evaluate the function of the prosthetic mitral valve. Only one valve leaflet was seen in motion (Figure 2) and this confirmed the diagnosis of valve dysfunction.

Figure 2. Fluoroscopy of St. Jude valve demonstrating only one leaflet open

The patient underwent an urgent operation under cardiopulmonary bypass. His left atrium was enlarged and nearly occluded with massive thrombus which extended into the St. Jude valve (Figures 3,4). A left atrial

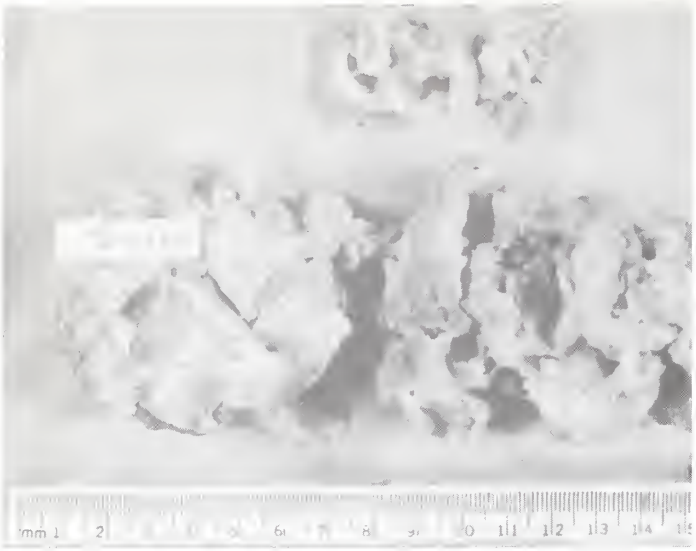


Figure 3. Massive left atrial thrombus

Figure 4. St. Jude medical valve

Figure 5. Postoperative chest X-ray showing pulmonary edema resolved

Figure 6. Normal fluoroscopy of St. Jude valve showing both leaflets open

thrombectomy was performed and the St. Jude valve was replaced. Since there is such a high incidence of calcification in porcine valves implanted in young patients, a 27 mm. St. Jude medical valve was chosen.

Postoperative recovery was uneventful. The postoperative chest X-ray showed resolution of his pulmonary edema (Figure 5). Anticoagulation was maintained with heparin until a prothrombin time of 20 seconds was reached with warfarin (coumadin). Repeat fluoroscopy was performed on the day of discharge and it showed normal function of his St. Jude valve (Figure 6).

Discussion

The St. Jude medical valve is one of the most popular of its class because it produces good results. This bileaflet central flow prosthesis has excellent hemodynamic and hydraulic properties which result in a low incidence of valve-related complications (1).

The most frequent complications of prosthetic heart valves are emboli, thrombi, and anticoagulant-related hemorrhage (2). Anti-coagulation with warfarin is the most important factor affecting the incidence of thrombi with mechanical valves (3). It is essential that all patients with mechanical valve protheses be maintained for life on treatment with warfarin.

The clinical features of valve thrombosis include dyspnea with light exertion, pulmonary edema, syncope, fatigue, fever, dizziness and vomiting (4). Thrombotic occlusion may be unrecognized, subsequent death being attributed to congestive heart failure, arrhythmias, or unknown causes. Risk factors which increase the incidence of thromboembolism include chronic atrial fibrillation, aneurysmal dilatation of the left atrium, increased age, left

atrial thrombus, and chronic low output state (5). As in this case, inadequate coagulation is a problem.

Recognition of these complications is of the utmost importance. Transthoracic echocardiography is often used but not always reliable. Transesophageal echocardiography is more sensitive but is not available in all hospitals. Fluoroscopy is useful to evaluate the range of motion or diagnose dysfunction of the St. Jude medical valve. With normal function, two valve leaflets can be seen as parallel lines when the valve is open. If only one leaflet is seen, valve dysfunction exists. Since fluoroscopy is available in all hospitals, it should be used as an initial screening test, and it can lead to prompt medical or surgical treatment.

References

1. Duncan JM, Cooley DA, Reul GJ, et al. Durability and low thrombogenicity of the St. Jude medical valve at 5-year follow-up. Ann Thorac Surg 1986;42:500-5.
2. Arom KV, Nicolloff DM, Lindsay WG, Northrup WF III. St. Jude medical prosthesis: valve related deaths and complications. Ann Thorac Surg 1987;43:591-8.
3. Edmunds LH Jr. Thrombotic and bleeding complications of prosthetic heart valves. Ann Thorac Surg 1987;44:430-45.
4. Renzulli A, DeLuca L, Caruso A, et al. Acute thrombosis of prosthetic valves: a multivariate analysis of the risk factors for a life-threatening event. Eur J Cardio-Thorac Surg 1992;6:412-21.
5. Kinsley RH, Antunes MJ, Colsen PR. St. Jude medical valve replacement. In evaluation of valve performance. J Thorac Cardiovasc Surg 1986;92:349-60.

New Manuscript Guidelines

All scientific manuscripts should be submitted on disc in the following languages: Wordperfect 4.2, 5.0, and 5.1; Word; Word for Windows; and WordStar. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

No more than 25 references will be published free of charge and they must be presented in the style based on the formats used by the U.S. National Library of Medicine in *"Index Medicus."*

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

An "above ground" pool hazard

HARVEY D. REISENWEBER, M.D.
Berkeley Family Medicine Associates, Inc., Martinsburg

Abstract

A previously unrecognized pool hazard is described in this article. The entrapment of an adolescent female by the filtration system of an above-ground pool and the difficulty in disarming the equipment was significant enough to be potentially quite dangerous.

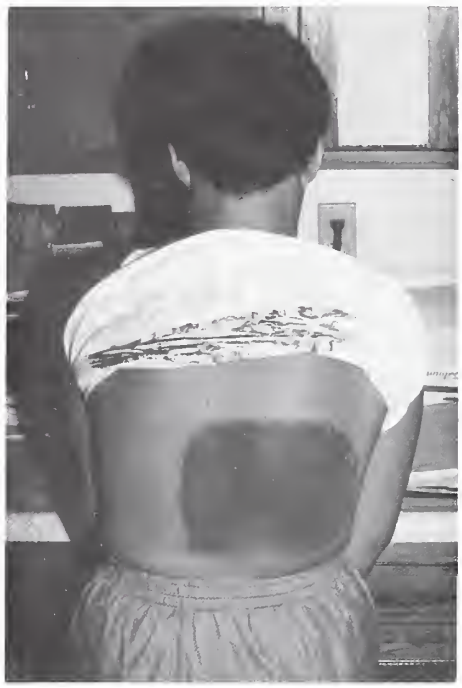
Introduction

The hazards of unsupervised home swimming pools are well known. The purpose of this article is to comment on a previously unrecognized pool hazard.

Case report

In August 1992, I saw a healthy, muscular 11-year-old female who had been traumatized by the filtration system of a neighbor's above-ground pool.

Apparently, this young lady slipped while she was in the pool and had her left lumbar/flank area suctioned to and held captive at the skimmer opening. The patient was unable to free herself in spite of moderately strenuous attempts to push away from the device. In addition, several of her friends were equally unsuccessful in pulling her away.



The affected area of the patient's back.

An adult promptly turned the pump mechanism off, thereby ending the pump's contribution to the suction; unfortunately, the negative pressure was maintained in the system because of the "collapsing" effect of the pool's walls on the pool liner. Thus, the patient was not freed until one of the water lines was disconnected.

The area of suction on the skin was immediately swollen and measured about 8 inches x 11 inches. It was initially erythematous, but later became ecchymotic and the swelling lessened. There was no evidence of any deeper structural injury and after two weeks the area had returned to normal. Attempts have been made to contact the manufacturer of the pool so that a convex screen or barrier device might be incorporated in the skimmer design.

Parents need to be observant of adolescent and pre-adolescent children who conceivably might be trapped by the filtration mechanism of a backyard pool -- even, perhaps, with their heads underwater at the time. Pool owners and visitors need to know how to promptly disconnect the water circuits, should the need arise.

Prasadarao B. Mukkamala, MD

Union Square • 1 Monongalia Street • Charleston, WV 25302

Dr. Mukkamala is a Diplomate of the American Board of Physical Medicine and Rehabilitation and the American Board of Electro-Diagnostic Medicine.

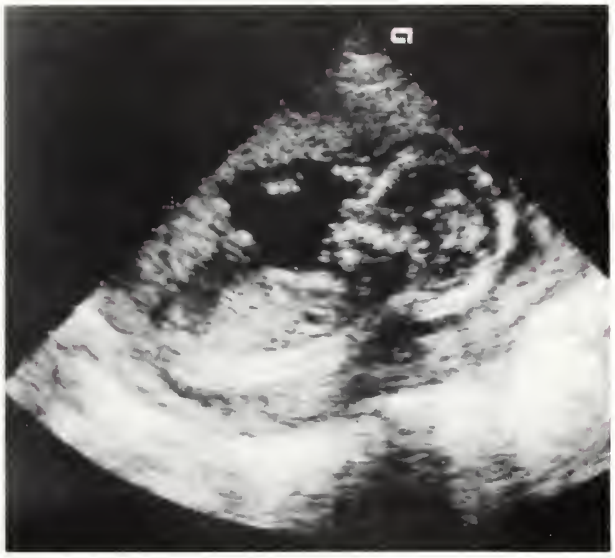
Specialist in Electromyography and Nerve Conduction Studies

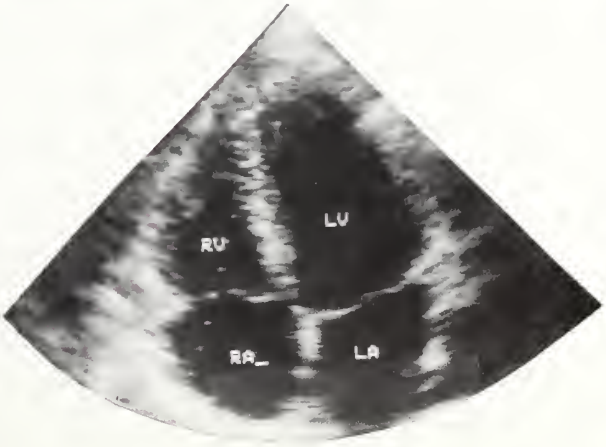
For appointment, call: **(304) 344-5153**

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time





SOUND

Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

President's Page

Robert P. Pullen MD.

The Medicaid gridlock

Medicaid, a federal-state health care program, is at the center of West Virginia's current legislative gridlock. Eighteen months ago, West Virginia adopted a voluntary provider tax program and greatly expanded Medicaid in terms of both services and the number of recipients. Now, the federal government has denied the voluntary tax program and the state is groping for ways to maintain the level of services and the number of recipients.

Medicaid has both mandatory and optional components and West Virginia has elected in the past to provide both of these components to the categorically needy and medically needy. West Virginia, in fact, is one of the most liberal states in additional optional benefits structure, and current discussions in the proposed health care bill would push eligibility for many recipients to 200% of the federal poverty level. For a family of four, that is equal to $28,000 per year in income.

Current federal regulations are 180 pages in length, but page 5 clearly states that if funds are raised through general revenue dollars, they will be matched at a rate of three federal dollars to one state dollar, and that recordkeeping to qualify under the remaining 175 pages of instructions will not be required. Governor Caperton has decided that providers should be responsible for funding Medicaid and the bureaucracy increase, and he steadfastly refuses to consider other sources of funding. He wants to place providers under the severance portion of the tax code (providers will be extracted from the state), the business and occupation tax and a special provider tax. Despite recommendations by his own Health Care Planning Commission that sin taxes, i.e. alcohol and tobacco taxes be used to fund health care, Governor Caperton has been adamant in refusing to consider these sources.

What does this suggest?

The chart on this page shows proposed Senate estimates and contains a wealth of information. Note that many services receive no general revenue dollars. Thus, those providers are funding that entire portion of the program for the state through tax dollars. No general revenue dollars are included in these accounts. Various providers are taxed at different rates from 1.25% for dentists, to 5.5% for nursing homes and ICF/MR.

Two distinct types of providers are taxed -- institutions and individuals. Institutions generally receive general revenue tax dollars and their tax assessments do not equal the budget when the match is applied. Institutions generally receive no cuts in reimbursements from Medicaid, and in general, reimbursements are increased to cover the cost of the tax.

Senate Medicaid Tax Proposal (In Millions)

Program	Budget*	General Revenue	Tax	Tax Revenues
Hospitals	247.9	28.0	2.5	40
Nursing Homes	199.7	35.3	5.5	14.61
ICF/MR	45.1	9.2	5.5	2.04
Home Health	3.9	1.0	0	0
Physicians	82.0	0	2.0	20.0
Pharmacy	83.0	20.7	0	0
Special Services	250.0	49.8	variable	14.61
Labs	4.9	1.2	0	0
Medicare	22.8	4.7	0	0
Clinics	11.2	2.8	0	0
Dentists	10.0	0	1.25	2.5
EPSDT	6.2	1.5	0	0
Transportation	5.4	0	5.0	1.33
Family Planning	.5	.1	0	0
Buy-in B	15.8	3.9	0	0
Buy-in A	13.2	3.3	0	0
Contracts	2.2	.5	0	0
Personal Care	1.1	.2	0	0
DPSH	61.5	15.0	0	0
Eligibility	14.4	4.0	0	0
PAAS	1.8	.3	0	0
Ambulatory Surgery	.7	.2	0	0
Litigation	12.1	3.5	0	0
		188.2		95.09

* Figures are rounded

Individuals, on the other hand, do not receive any general revenue tax dollars, suffer reimbursement cuts and are unable to pass the tax on by any increase in other reimbursements.

The proposed tax structure -- a tax on gross receipts -- is the most regressive anti-business tax possible since the tax is applied before deducting the cost of doing business. West Virginia is already known as an anti-business state. These taxes only further this perception.

State government expenditures between 1980 and 1992 outpaced the rate of inflation by 38.4%. During that same time period, West Virginia's population declined by 175,000+ residents. Most of those leaving the state were young citizens who fled to find jobs in other areas.

Several questions need answered and the leadership of state government, particularly Governor Caperton, Speaker Chambers, and Senate President Burdette have refused to address these issues. Their only suggestion has been provider taxes! The reason -- they perceive their future political careers could be damaged by any additional increase in general taxes. Yet, the process of taxing small specific groups, i.e. physicians, lawyers and contractors, offers the "slippery slope" of increasing revenues by avoiding the long standing taxation principle of taxing more people less -- not fewer people more!

Consider the following questions. Should Medicaid be funded by the general revenue source or by specific groups? Is health care for the disadvantaged a societal problem? How extensive should the program be? Should health care for the poor provide better benefits than private or group insurance plans? Should there be responsibilities on the part of recipients, i.e. co-payments, deductibles, and restrictions? Should there be a Medicaid program?

These are difficult and necessary questions. They must be extensively researched and answered before funding is considered. How should the program be funded? Put aside the level of funding -- Senate $1.143 billion, House $1.25 billion. These amounts require that state funds supply 24.41% of the necessary dollars. If one uses the figures shown in the chart, the state needs to raise $95 million in additional taxes to supplement the $184.2 million already going to the Medicaid fund from general revenues.

Are there possibilities other than provider taxes? Yes.

Consider the following alternatives:

1. Increase the general sales tax 1% to raise $117.6 million. This is $22 million more than the need estimated by the Senate and would be shared by all citizens of the state. Actually, an increase in the sales tax to 6.8% would raise the amount needed.
2. Increase state income tax rates from 3% to 3.42%, 4% to 4.56%, 5% to 5.7%, and 6.5% to 7.4% to raise a similar amount of funds. Persons earning less than $60,000 would pay less than .80¢ per day to support the Medicaid health system.
3. Reduce the recently passed gasoline tax from five cents to two cents per gallon, which is the actual amount needed for new construction, and raise the sales tax to 7%.
4. Tax institutional providers as described in the Senate proposal since they are in a win-win situation. Remove the provider tax on individuals, reduce the food tax to zero and raise the general sales tax to 7% or 7.5%.
5. Use "sin taxes," i.e. taxes on alcohol and tobacco to further decrease the rates already mentioned.
6. Consider the previous Caperton proposal of a 1% increase in tax rates above $100,000 to reduce the plans stated in numbers 1 and 2 above.

There are multiple other possibilities and permutations that spread the burden to all West Virginians, not just the health care segment.

What is the health care segment? It is 70,000 people in West Virginia employed in the health care field. A provider tax directed at individuals will only directly tax a few, but the ripple effect will extend to each and every individual employed in the field. How will it ripple? Hospitals taxed at 2.5% or 3.5% of gross receipts will be unable to cost shift to non-government payors and thus will reduce staff, reduce or eliminate annual raises, increase employee cost for hospital-sponsored health plans, reduce contributions to pension plans and increase charges where possible. Other providers will do the same in an attempt to recover the onerous tax burden.

What about the future of West Virginia health care? A significant regressive tax will probably cause Providers located on the state's borders, to seek asylum in neighboring states where taxes and malpractice rates are much less. Recruitment of new physicians and retention of state medical graduates will become almost impossible because of the financial implications of locating in West Virginia. Rural physicians whose expenses are high and incomes low will be forced to close their practices. Marginal hospitals will reduce services or be forced to close.

The state Medicaid Department has already announced reimbursement reductions of 30% to individual providers and less restrictive reductions to others. Is this fair when providers who agreed to the voluntary program of the past year were promised enhanced payments for services through June 30, 1993, as an inducement to participate in the program? In addition, Medicaid payments to providers are now more delinquent than ever in the history of the program. Many offices have not been paid for over six weeks and are borrowing money to meet payrolls. Viewed from the outside, management at the Medicaid Department is a shambles and getting worse.

What is the solution? The solution involves **you**, the citizens of West Virginia. **You** must decide and communicate that decision to the governor and to the leadership of the state. Failure to do so will lead to a policy decision by the leadership of the state to tax individual small groups to enhance government revenues, a slippery slope that will lead ultimately to more taxes and bigger government bureaucracy. Neither of these are needed!

WESPAC

West Virginia State Medical Association's
Political Action Committee

With so many challenges facing organized medicine, it is imperative that we have support in the Legislature. The need for political action has never been greater!

Write your personal check to WESPAC today and help us strengthen our role in the legislative process.

$50 - Regular **$100 - Sustainer**
$150 - Extra Miler

Mail your personal check to:

WESPAC
P.O. Box 4106
Charleston, WV 25364

Frank J. Holroyd, M.D., R.I.P

Counting himself, there were five past presidents of the WVSMA at his funeral. The four living ones certainly remembered him. He was a quiet man, but it just didn't seem right to see or to remember him that quiet. Frank Holroyd was dead all right.

Dr. Holroyd's brain had died eight or nine years before his heart stopped on April 10, 1993 -- a bracing kind of an Alzheimer's tragedy. How could a man so penetrating and insightful, so quick to read the slightest hint of meaning or intent on the face of friend or foe, suddenly lose those skills and through the deepening fog of memory start greeting strangers, relatives and long acquaintances alike with "Hi ya, Bud."

It was a different Frank Holroyd we wrote about in the *Journal* in 1971 following his successful campaign management of Huntington's Carl Hoffman to the presidency of the American Medical Association in 1970. That campaign followed an equally successful one for his friend Wes Hall from Nevada to the same office the previous year.

In that August 1971 editorial we noted:

> "There is an old saying to the effect that a prophet is without honor in his hometown. To a certain extent this is true for Frank Holroyd. Certainly, there are relatively few doctors in West Virginia aware of the enormous respect which this man commands with AMA officials throughout the country.
>
> "A man like Frank generates a lot of feeling – some positive, some negative. This happens because men like him are doers, and people who do things sometimes interfere with others trying to do things, and sometimes they step a little bit on the sitters. As a consequence, some have liked Frank and some have not; but, like him or not, it is impossible to know him at all and fail to respect him. Over the years Frank has had causes, has advocated things, has pushed for things. It has not always been obvious why, and some of his causes have been controversial, but time has always seemed to prove his wisdom and to vindicate his judgment."

Holroyd

For a score of years, no serious candidate would think of running for high office in the AMA without consulting Frank Holroyd for a candid evaluation of his chances. No longevity records are kept, but it is likely that no one ever served in the AMA House of Delegates longer than his 32 years of service. And no one was ever more highly regarded and respected.

The funeral cortege was a long one wending its way from Princeton to Athens where he was born. Occupants of the automobiles were mostly gray-haired. The day was beautiful and bright. The cemetery on top of a hill was breezy but quiet. In the distance you could see the buildings of Concord College from which he graduated. In the far distance, grey-blue mountain ridges.

Old tombstones announced the presence of Holroyd kin dating back to early last century, all gathered in welcome. They will find Frank a quiet man, but if they have any kind of an organization on top of that hill, they will surely have a new man running it very shortly.

Mary, Frank's wife, has set up medical scholarship funds at two different Princeton churches. A contribution to one or both will help to recall a man who merits remembering.

– SDW

Please see the news article about the medical scholarships on page 204 and Dr. Holroyd's obituary on page 219.

Guest Editorial

Deeefense

Physicians might not be aware of the fact that medical malpractice claims are increasing again in number and in cost. Forty medical malpractice companies reported an increase in claims in 1991, and last year, a major national provider of liability coverage reported an increase in the frequency of claims for the first time since 1985.

West Virginia has not escaped the national trend of claim inflation and, because of this, major West Virginia physician malpractice carriers have implemented rate increases for West Virginia physicians in 1993.

There are a number of active things that physicians can do to help make their practices more defensible against allegations of medical malpractice. As an example, studies clearly show that poor patient relationships and problems of ineffective communications can be major precipitants of claims alleging medical error. These and other motivators can be identified and addressed in an effective manner. The result will be to improve a physician's claims track record by reducing avoidable claims.

The West Virginia State Medical Association supports the McDonough Caperton practice survey service currently being offered. The service involves an on-site survey of the practice by experienced health care risk managers familiar with malpractice claims. Through interviews, review of procedures and other risk assessing techniques, the practice is evaluated for potential malpractice exposure and for a successful defense against such allegations when plaintiff's attorneys attack. A fee will be charged by McDonough Caperton for this service, but a portion of the funds obtained from each fee will be sent to the West Virginia State Medical Association to help continue its malpractice educational program.

The cost of this service, when measured against the cost of litigation, both in terms of lost dollars and psychological damage to physicians, is more than worth the money. This service provides a way to make your medical practice defensible. It is worth your careful consideration.

Please refer to the facing page for an ad with additional information about a survey of your practice.

John B. Markey, M.D.
Chairman
WVSMA Insurance Committee

Our Readers Speak

I read with interest the editorial in the February issue regarding the medical community cheering President Clinton's actions on the abortion issue. I would agree with the editor in his assessment of the situation wherein the media definitely misrepresented the medical community. You heard no cheering from me.

I do, however, have one comment to make about the AMA's position on this issue. Your editorial stated that the AMA says that where abortion is legal it is ethical. This is a dangerous assumption to make on the part of the AMA because, as you will remember, the murder of certain minority groups in Germany during World War II was legal, but I am sure the AMA would not consider that ethical. You will also remember, I am sure, that the Supreme Court was wrong in the 1853 Dred/Scott decision wherein they ruled that slaves were not human beings and that slavery was therefore legal. Did that ruling make slavery ethical?

Therefore, it is my opinion that even though abortion is legal, it is unethical.

Joseph A. Snead, M.D.
Weston

If he had only managed his *Risk* as well as he practices medicine...

Medical malpractice suits aren't only lost by doctors guilty of malpractice. Of the hundreds of suits brought each year, a large percentage are lost due to the lack of a defense caused by office procedures such as poor medical record documentation.

Good risk management practices not only improve your ability to defend yourself against malpractice suits, they protect your insurability, and can ultimately effect insurance rates.

McDonough Caperton Insurance Group, West Virginia's leading provider of medical malpractice insurance, has developed a comprehensive and inexpensive Physician Practice Risk Survey. We evaluate your practice's exposure to risk, and recommend systems and procedures which make good risk management sense.

For more information call or write today!

McDonough Caperton/ABI
One Hillcrest Drive, East
Charleston, West Virginia 25311
(304) 347-0684

"Adding Value Through Specialized Service!"

McDonough Caperton

ABI American Business Insurance

American Medical Association
Physicians dedicated to the health of America

For Your Benefit

White House responds to AMA message

Medicine's message is being heard on Capitol Hill as a result of the AMA-sponsored event, "A Time for New Partnership." The event attracted more than 1,000 physicians from every state to Washington, D.C., March 23-25.

In the words of AMA Executive Vice President James S. Todd, MD, "This town hasn't seen anything like what we've done here since the health care debate first heated up nearly two years ago."

Media coverage of the event positioned the AMA as an influential player. News reports were carried in the *New York Times*, *Washington Post* and *USA Today*. Ninety-nine reporters covered the event, which also resulted in coverage on "World News Tonight," "CBS This Morning," and two segments on the PBS "MacNeil/Lehrer News Hour."

Vice President Al Gore spoke to participants, saying the Clinton Administration "knows that we cannot, and do not want to, build a better health care system without the cooperation and leadership of the AMA."

Political heavyweights from both parties spoke, including Senate Majority Leader George Mitchell (D, Maine), Senate Minority Leader Robert Dole (R, Kan.), Sen. Edward Kennedy (D, Mass.), HHS Secretary Donna Shalala and other top leaders.

On day two of the event, the AMA organized groups of physicians to meet with their congressional representatives.

Also while in Washington, AMA's Board of Trustees met with Ira Magaziner for the fourth time. The meeting resulted in a "full and productive exchange of ideas." Magaziner asked for input from the medical profession on system reform. AMA trustees said many elements of the administration's proposal are in sync with the AMA's Health Access America plan.

HCFA extends Medicare claims denial deadline

After intensive efforts by the AMA, the deadline for denial of Medicare claims that lack a CLIA registration number is extended indefinitely by HCFA.

The agency initially published final regulations under which Medicare would have started denying claims for lab tests when there was no CLIA registration on file as of Sept. 1, 1992.

The deadline was originally extended to Dec. 1, 1992. HCFA subsequently decided its internal data processing system required modification and extended the deadline to March 1.

The agency then said an indefinite extension was needed to analyze claims processing requirements.

Prepared by the Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

Action urged to prevent violence against physicians, other providers

The AMA denounces senseless acts of violence against physicians, nurses, and other health care workers and urges action to make health care workplaces safer.

"The AMA and its professional colleagues are calling for a unified effort from each health care profession, from our government leaders, and from the American public to send a message that the harassment, threatening, maiming and killing of those who take care of patients must stop," said William E. Jacott, MD, AMA secretary-treasurer, at a Washington, D.C., news conference.

AMA officials outlined specific measures to prevent violent incidents. They also asked the Justice Dept. and Congress to take action.

The AMA stressed these actions:

- Justice Dept. investigation into groups and individuals known to target physicians, researchers and other health care providers.
- Congressional hearings on violence against health care workers and the drafting and enactment of a "Health Care Protection Act."
- Establishment of federally defined safe zones for hospitals and clinics, research laboratories, academic health centers and other health facilities.

The AMA said continued violence against health care workers will limit access to medical care. Fewer physicians will work in emergency departments, and "physician flight will result in restricted access to medical care in certain areas."

Clinical research: Women must be included

The AMA believes medical research needs to involve women in all clinical trials that can have an impact on women's health.

AMA Trustee Palma E. Formica, MD, delivered this AMA message to the Office of Research on Women's Health. She discussed issues and strategies for increasing the recruitment and retention of women in clinical studies.

Dr. Formica also recommended increasing the number of female biomedical researchers and the number of female researchers in leadership roles and other positions of authority.

"Inconsistencies exist, often to the disadvantage of women's health," Dr. Formica noted. "Gender-related factors are ignored frequently when health interventions derived from studies of men are generalized to the entire population."

She said that additional costs to include women in clinical studies are vital to "learn with confidence whether findings do indeed apply to the population at large." Women respond differently to treatment than men.

Prepared by the Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

New CME event to be offered at Annual Meeting

Lunch and Learn

Designed to nurture both the minds and the bodies of the participants, a new "Lunch and Learn" CME event has been added to the program at this year's WVSMA Annual Meeting, which will take place at The Greenbrier from August 18-21.

Set for Thursday, August 19 at noon, this luncheon will feature a panel discussion entitled "Family Violence - Exploring the Caregivers' Legal and Ethical Responsibilities" that will be headlined by Cleveland attorney Ronald E. Alexander. Joining Alexander on the panel will be William H. Beeson, M.D., president of the Indiana State Medical Association; Joseph Snyder, M.D., president of the Medical & Chirurgical Faculty of the State of Maryland; Stanley J. Lucas, M.D., president of Ohio State Medical Association; George Broman Jr., M.D., president of the Medical Society of Virginia; William B. Monnig, M.D., president of the Kentucky Medical Association; and Pacita Salon, president of the WVSMA's Auxiliary.

Of counsel to the firm of Arter & Hadden in Cleveland, Alexander received his J.D. degree from the Ohio State University College of Law in 1971, and his LL.M. degree from the University of Pennsylvania College of Law in 1978. An adjunct professor at the Northeastern Ohio Universities' College of Medicine, Alexander is also a trustee for the foundation at this institution. In addition, he is a member of the National Health Lawyers Association, the American Academy of Hospital Attorneys and the Ohio Society of Hospital Attorneys.

According to Alexander, the physician plays a critical role in assisting the victims of domestic violence because he or she is often the one person outside their families, who they feel comfortable talking with about their problems.

Alexander

"Physicians do so much more than just treat their patients' physical injuries, but their mental and emotional wounds as well," Alexander said. "People look to physicians as the family patron. This CME luncheon will provide a valuable opportunity for participants to learn about the legal perspectives of family violence situations, as well as share their own personal experiences. The forum for this presentation will be very open so there can be a great deal of discussion about what is being done in West Virginia, as well as in the other states whose medical society presidents will be on the panel," he added.

Alexander noted that too often the media depicts physicians as individuals who only care about reimbursement and malpractice liability, and do not focus on physicians' real number one concern -- their patients.

"This forum will show how physicians, auxilians and medical societies are meeting the needs of society today by addressing the devasting problem of family violence," Alexander commented. "The medical profession is the gatekeeper in protecting the needs of the patients."

This session is open to all participants at the WVSMA's Annual Meeting. The fee for WVSMA members and other physicians is $25 and a special rate of $15 is being offered for spouses and medical students.

The Lunch and Learn format will also be utilized for this year's WESPAC meeting at the Annual Meeting. CME credit has also been requested for this meeting, which is scheduled for noon on Friday, August 20, and will highlight the activities of WESPAC, AMPAC and the PACs in other area states. AMA president Dr. Joseph T. Painter will be participating in this event along with Drs. Beeson, Snyder, Lucas, Broman and Monnig, who will also be panelists for the Lunch and Learn on family violence.

To register for the Annual Meeting and either of the Lunch and Learn sessions, please mail in the form on page 207. For further details about this year's conference, phone Nancie Divvens at (304) 925-0342.

Scholarship funds created in memory of Dr. Holroyd

In honor of WVSMA Past President Dr. Frank J. Holroyd, who died on April 10, his wife, Mary, has established memorial scholarship funds at both First Baptist Church and First United Methodist Church in Princeton.

Scholarships will be awarded by committees from each church to deserving students who wish to pursue careers in health care. Anyone wishing to donate to this fund should mail their contributions to either First Baptist Church, 1116 Mercer Street, Princeton, WV 24740 or First United Methodist Church, P.O. Box 304, Princeton, WV 24740.

An editorial about Dr. Holroyd appears on page 199 in this issue of the *Journal*, and his obituary is printed on page 219.

Legislative Briefing

George Rider, WVSMA executive director, discusses the WVSMA's proposed tort reform legislation with members and other individuals who attended a special meeting at the Cultural Center at the State Capitol on April 19.

WVSMA members raise funds for orthopaedic research

Kyle R. Hegg, M.D., of Huntington, medical director of the Orthopaedic Research and Education Foundation (OREF), has announced that $16,020 was raised in West Virginia for the 1992 Campaign for the Future of Orthopaedic Surgery. Nationwide $3.875 million was collected for this effort, which will fund 58 new grants, one of which will be given to WVSMA member J. David Blaha, M.D., of WVU, for a research project.

Under Dr. Hegg's direction, Charles Capito, M.D., Weirton; Charles M. Davis Jr., M.D., Morgantown; Stephen I. Lester, M.D., Elkins; Carl J. Roncaglione, M.D., South Charleston; David Santrock, M.D., Charleston; Thomas F. Scott, M.D., Huntington; and Doyle R. Sickles, M.D., Clarksburg; led the volunteer effort to solicit their colleagues to join the Order of Merit with contributions of $1,000 or more. They enrolled 15 of their fellow orthopaedic surgeons and raised the $16,020.

The OREF offers an extensive program of individual, departmental, institutional and society grants and awards, and August 1 is the deadline for the 1994 grants. For further information and applications, contact Katherine T. Walker, Director of Grants, OREF, 6300 North River Road, Rosemont, IL 60068-4261, (708) 698-9980.

New aging association to meet in Morgantown

The recently created West Virginia Aging Alliance Inc. will conduct a welcoming reception on June 8 at 7 p.m. in the Erickson Alumni Center on the WVU campus in Morgantown.

The West Virginia Aging Alliance was established last fall to bring together the numerous individuals and groups who work with and for older persons in the state. All members and potential members are invited to attend the reception.

For more information about this event or the alliance, phone 293-2018.

Otolaryngology alumni conference set

The Fourth Annual Otolaryngology - Head and Neck Surgery Alumni Conference will take place at the West Virginia University Health Sciences Center from June 19-20.

This year's Philip M. Sprinkle lecturer is Dr. James Y. Suen, renowned head and neck cancer surgeon.

For further information, contact Carol Panepinto at 293-4921.

Dr. Tully receives Family Doc Award

Tully

Dr. C. Carl Tully of Charleston has received the Family Doc Award, the highest honor granted by the West Virginia Chapter of the American Academy of Family Physicians (WVAAFP). This award is presented each year to a family physician who, in a very special way, has earned the respect of patients and colleagues.

Dr. Tully was born June 22, 1913, in Charleston. He received B.S. degrees from Morris Harvey College and the West Virginia University School of Medicine, and obtained his medical degree from the Medical College of Virginia in 1947.

Dr. Tully served in the United States Armed Forces from 1943-46 and again from 1951-53. A diplomate of the American Board of Family Practice and a fellow of the American Academy of Family Physicians, Dr. Tully has practiced medicine in Maryland, Texas and West Virginia, and he recently retired as employee health director/medical coordinator at St. Francis Hospital in Charleston.

During his career, Dr. Tully was on the staffs of Charleston Area Medical Center and Thomas Memorial Hospital. He is a past president of Thomas Memorial's medical staff and has held several medical staff leadership positions at the hospital. In addition, Dr. Tully was a professor in the Family Practice Division of the WVU School of Medicine, and was the director of the Kanawha Valley Family Practice Center from 1973-79.

Devoted to community service, Dr. Tully was a member of the Kanawha County Board of Education from 1958-70, serving as president from 1964-66. He also served as president of the South Charleston Parks and Recreation Commission, and in 1964 was selected South Charleston Citizen of the Year.

A member of the WVSMA since 1949, Dr. Tully is a past president of the West Virginia Chapter of the American Academy of Family Physicians and a member of the Kanawha Medical Society.

The WVSMA & Conomikes Associates, Inc.

Present

MANAGED CARE

How to deal with it properly

- How to avoid HMO/PPO contracting traps
- Capitation vs. Fee-for-Service
- How to get paid what you deserve

Charleston - September 28 Charleston Area Medical Center
3110 MacCorkle Avenue
9 a.m. to 4 p.m. (Lunch provided)

Registration Form

MANAGED CARE: How to deal with it Profitably

Enrollee Name _____

Physician's Name _____

Address _____

City _____

State _____ Zip _____ Phone _____

WVSMA member ($195) _____ Non-member ($225) ____
2 or more ($175) _____ 2 or more ($200) _____

Payment by: Check ___ Visa ___ Mastercard ___

Card Number _____

Expiration Date _____

Signature _____

Registration Fees:

$195 per person (Members/Member's Office staff)
Two or more persons from the same practice $195 for the first enrollee and $175 for each additional enrollee

$225 per person (Nonmembers/Office Staff)
Two or more persons from the same practice $225 for the first enrollee and $200 for each additional enrollee

NOTE: To register more than one person, copy and complete information on a separate sheet.

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

The West Virginia State Medical Association's

1993 Annual Meeting

August 18-21, 1993

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up Now!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

For more details about other area hotels/motels, contact the WVSMA at 304-925-0342. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1993 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code _____

Specialty _____

Payment by: Check Visa MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	____
	non-member	$175	____
Additional:			
Thursday, Aug. 19 Lunch and Learn (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
Friday, Aug. 20 WESPAC Luncheon (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
		TOTAL:	____

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

May 20 - Marbury v. Madison Loss Control Seminar, Morgantown

CAMC/WVU Health Sciences Center - Charleston

June 1 - "Management of Congenital Tumors of the Neck," R. Austin Wallace, M.D., F.A.C.S., (sponsored by the WVU Dept. of Surgery and the Eye and Ear Clinic of Charleston, Inc.), 5:30 p.m., Faculty Lounge, 4th Floor, WVU Health Sciences Center

June 3 - "Teleconference on Neonatal Resuscitation and Stabilization," noon, WVU Health Sciences Center and satellite locations

June 10 - "Teleconference on Management of Abnormal Pap Smears in the Pregnant Patient," noon, WVU Health Sciences Center and satellite locations

June 17 - "Teleconference on Infants of Diabetic Mothers," noon, WVU Health Sciences Center and satellite locations

WVU Health Sciences Center - Morgantown

May 21 - "Adolescents in Your Pediatric Practice," (sponsored by WVU Dept. of Pediatrics), Lakeview Resort and Conference Center, Morgantown

June 19-20 - "Fourth Annual Otolaryngology-Head and Neck Alumni Conference," WVU Health Sciences Center Auditorium

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Gassaway ☐ Braxton County Memorial Hospital, June 9, 7 p.m., "Health Promotion and Disease Prevention in the Elderly, or Eight Questions Your Elderly Patient May Ask," Mark Newbrough, M.D.

Madison ☐ Boone Memorial Hospital, June 8, 6:30 p.m., "Medical Management of Low Back Pain," Janet Cochran, M.D.

Man ☐ Man Appalachian Regional Hospital, June 15, 7 p.m., "Complications of Surgery for Primary Care Physicians," Rakesh Wahi, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, May 26, 7 a.m., "Hepatitis from A-E," John Thomas, M.D.

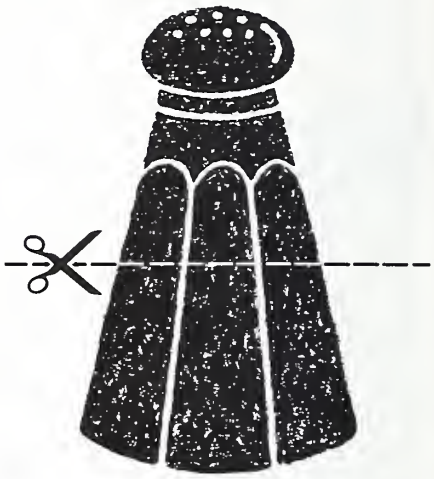
Point Pleasant ☐ Pleasant Valley Hospital, June 24, noon, "Use and Abuse of Antibiotics," Marcel Lambrechts, M.D.

Ripley ☐ Jackson General Hospital, June 11, 12:15 p.m., "Cervical Spine Injuries," Alfredo Velasquez, M.D.

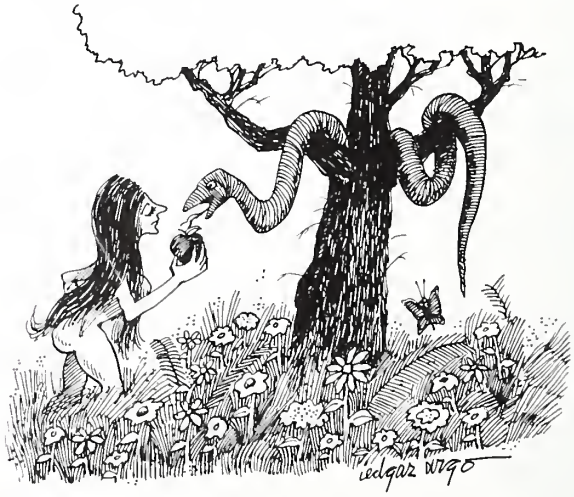
Spencer ☐ Roane General Hospital, June 15, 12:30 p.m., "Clinical Health Psychology," Paul Blanton, Ph.D.

Go against the grain. Cut down on salt.

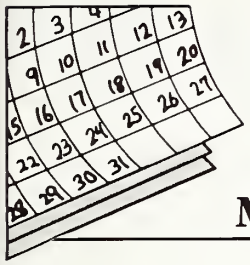
Adding salt to your food could subtract years from your life. Because in some people salt contributes to high blood pressure, a condition that increases your risk of heart disease.



American Heart Association



"GO AHEAD... EAT IT... IT'S ONLY 55 CALORIES."



Medical Meetings

May

28-31–11th National Annual Spring Meeting of the West Virginia Academy of Otolaryngology - Head and Neck Surgery, Inc., White Sulphur Springs

June

2-5–American College of Sports Medicine, Seattle, Wash.
6-9–Ninth Annual EVMS Family Medicine Review Course (sponsored by Eastern Virginia Medical School), Virginia Beach, Va.
7-9–The Fifth Global Congress on Computer-Based Health Records and Patient Data Cards (sponsored by Medical Records Institute), Venice, Italy
8-9–Society for Vascular Surgery, Washington, D.C.
9-15–American Diabetes Association, Las Vegas, Nev.
10-13–National Association of EMS Physicians, Minneapolis, Minn.
12-16–Board Review in Family Practice (sponsored by The George Washington University Medical Center), Arlington, Va.
13-16–Ohio Valley Society for Plastic and Reconstructive Surgery, Columbus
13-18–XIIth International Congress of Nephrology (sponsored by the International Society of Nephrology), Jerusalem, Israel
15-18–Interhospital 93 and 18th Hospital Congress (sponsored by Hannover Fairs USA, Inc.), Hannover, Germany
16-19–Sixth International Symposium of the American Academy of Facial Plastic and Reconstructive Surgery, San Francisco
17-18–Cardiology for the Elderly (sponsored by Ohio State University), Columbus
20-24–International Conference on Cornea, Eye Banking and External Diseases, Jerusalem, Israel
24-27– American Congress of Rehabilitation Medicine, Denver, Colo.
25-27–Eleventh Summer Symposium in Internal Medicine (sponsored by Eastern Virginia Medical School), Williamsburg, Va.
27-29–American Society of Contemporary Medicine and Surgery, Chicago
27-30–American Society of Contemporary Ophthalmology, Chicago

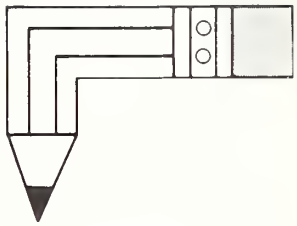
July

9-11–American College of Allergy & Immunology, Denver, Colo.

For More Information . . .

Contact the Journal at (304) 925-0342

Poetry Corner



Final Beginning

In this life that we live,
There are many beginnings;
But each one comes about
Through a series of endings.

When a pregnancy ends
A new baby is born,
Like a giant oak grown
From a tiny acorn.

And when teenage years start
Days of childhood and play,
Having passed by so fast,
Are too soon put away.

Then from teen to adult
You soon find yourself going,
As the young years have passed
Like a wind that is blowing.

When the older years come
One starts looking ahead
To the final beginning
Without sense of dread.

For the final beginning
Gives new life to the soul;
And if our lives have meaning,
We're prepared for that goal.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Special Note

If you are interested in becoming a member of the American Physicians Poetry Association and receiving their quarterly newsletter, send $25 ($15 for medical students) to William J. Wortman, M.D., 2711 Randolph Road, Suite 309, Charlotte, N.C. 28207.

This page of material is submitted and paid for by the Bureau of Public Health.

Panepinto named new DHHR secretary

Ruth Ann Panepinto, Ph.D., has been named the secretary of the Department of Health and Human Resources. Dr. Panepinto was previously the commissioner of the Bureau of Human Resources within the DHHR and has served in state government for more than 25 years.

Dr. Panepinto received her Ph.D. degree in clinical psychology and her master's degree in rehabilitation counseling from West Virginia University. She also attended the Western College for Women where she obtained an A.B. degree in psychology.

In addition to being a licensed clinical psychologist, Dr. Panepinto is both an adjunct clinical assistant professor in the Department of Behavioral Medicine and an adjunct associate professor in the Department of Psychology at West Virginia University.

Health officials stressing regular tetanus boosters

Officials of the West Virginia Bureau of Public Health are issuing a reminder that a tetanus booster shot should be given every 10 years throughout adult life.

Due to the effectiveness of the diphtheria, tetanus and pertussis vaccine (DTP) given during childhood, tetanus in the United States is a relatively uncommon disease. Between 1989 and 1990, there were 117 cases reported to the Centers for Disease Control. The last reported case of tetanus in West Virginia occurred in 1988.

Tetanus, though, continues to be a severe disease that primarily affects older adults who are unvaccinated or inadequately vaccinated. The number of people lacking protective antibodies against tetanus and diphtheria increases with age. It is estimated that between 31% and 70% of older adults lack protective levels of those antibodies. Elderly people living in rural settings are more likely to be unimmunized than those in urban settings.

Primary care physicians should remind and encourage patients, especially the elderly, to review their vaccination status. When indicated, the tetanus diphtheria (Td) and other vaccines should be given as needed, and, again, it is recommended that the tetanus booster be given every 10 years.

For more information about tetanus or the Td vaccination, contact Sam Crosby at (304) 558-2188.

Lead poisoning less prevalent in state than in nation

Early findings indicate that while West Virginia children are not entirely free and safe from lead poisoning, there is a relatively low incidence of early childhood lead poisoning in the Mountain State compared to national figures.

An informal report on childhood lead poisoning has recently been released by the West Virginia Bureau of Public Health. The report is based on screenings of children under the age of six enrolled in the Medicaid-funded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Required by federal law, the screenings are being used as a pilot to determine the need for further lead poisoning prevention activities in the state. Some children were also tested through the Pediatric Health Services Program for non-Medicaid eligible low income children.

The first available results from the screenings, which began last year, show that nearly 85% (5,817) of the 6,893 children tested had blood lead levels of less than 10 mcg/dL, which is the newly-established CDC acceptable level. Slightly more then 12% (868), of the total were in the borderline-acceptable range of 10-15 mcg/dL. Three percent of these children (208) were found to be in the lead-poisoned range above 15 mcg/dL. In addition, 184 of these children or 2.7% were in the 16-24 mcg/dL range; 24 or 0.3% were in the 25 mcg/dL or over range; and at least one was hospitalized for treatment of lead poisoning.

The Bureau will continue to screen EPSDT participants and will be conducting public education to further reduce lead exposure in the state.

For more information on the blood lead level screenings, contact Dr. Mary Skinner at (304) 558-5388.

Parents reminded about hemoglobinopathy testing for newborns

Hemoglobinopathy testing for newborns is not mandated by West Virginia Statutes, but is offered instead as an option. **Therefore, if the test is to be performed it must be requested by making the "yes" box on the Office of Laboratory Services' Newborn Screening Form to indicate the desire to have hemoglobinopathy testing.**

The Office of Laboratory Services' hemoglobinopathy testing program is primarily directed toward the detection of sickle cell anemia in black newborns. However, newborns with ethnic origins from other areas may also have hemoglobin abnormalities. In particular, individuals from Asia, India, South and Central America, Mediterranean and Caribbean areas, and oriental countries/regions are at greater risk for the inheritance of sickle cell disease and other hemoglobin abnormalities.

For more information on newborn hemoglobinopathy testing, contact Frank Lambert at (304) 558-3530.

EENT Seminar for Primary Care Physicians 1993 Update

Topics Include:
Sinusitis
Ophthalmic Emergencies
Common Pediatric EENT Conditions

DATE
Saturday, May 22, 1993

LOCATION
Charleston Marriott

CREDIT
4.5 Hours AAFP
4.5 Hours CME Credit, Category I

SPONSOR
The Eye and Ear Clinic of Charleston, Inc.

CO-SPONSOR
Department of Family Medicine
WVU Health Sciences Center
Charleston Division
Charleston Area Medical Center

For Registration Information, Call:
353-0324
Toll-Free in WV:
1-800-642-3049, ext. 324

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

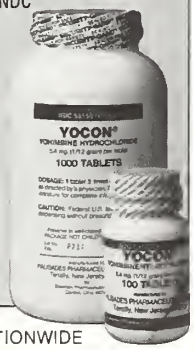
Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center, Communications Division, Morgantown

Campus to be named for Senator Byrd

Senator Robert C. Byrd

As of June 5, the WVU Health Sciences campus will be rededicated as the Robert C. Byrd Health Sciences Center. The University of West Virginia system trustees approved the name change on April 1.

The name will apply to the entire campus, including the Health Sciences Building; Ruby Memorial Hospital; the Mary Babb Randolph Cancer Center; Chestnut Ridge Hospital; MountainView Regional Rehabilitation Hospital; the Physician Office Center; and NIOSH.

Dr. Robert D'Alessandri, vice president for health sciences and dean of the School of Medicine, says he will be proud to lead a campus with Byrd's name.

"This name will help us realize that all of us are part of the same effort - - to improve the health of West Virginians," Dr. D'Alessandri says. "We have state employees, federal employees and private enterprise all working together here. Having Senator Byrd's name on the campus will give us all a common identity, and will be a continual reminder that we owe our existence to the people of West Virginia."

WVU establishes Health Sciences and Technology Academy

WVU has established a program to promote and support interest in health sciences and technological studies among African American and economically disadvantaged seventh through 12th grade students.

The WVU Health Sciences and Technology Academy, which will begin this summer, is part of WVU's effort to increase the numbers of minority students in medical school and other health professions programs.

Up to 100 seventh graders, and their parents, will be invited to an orientation session at WVU this summer. Those who choose to continue with the program will have the opportunity to spend three weeks at WVU each summer from eighth grade through high school.

The program will be coordinated at WVU by the Center for Black Culture and Research, the Health Sciences Center Office for Social Justice and the Office of Community and Continuing Professional Education.

Neal attends National Summit on Children and Families

Dr. William Neal, professor and chair of the Department of Pediatrics, was in Washington, D.C. recently as one of 200 participants attending the National Summit on Children and Families.

The Summit marked the end of the National Commission on Children, created by the President and Congress in 1989. In June 1991, the Commission, chaired by Senator Jay Rockefeller, unanimously approved a comprehensive agenda for policy and program development.

Dr. Neal met with a select group of leaders from across the country to exchange ideas on the challenges facing the nation, priorities and workable approaches for action, and the opportunity and promise of new leadership.

Researchers studying anesthesia costs

Johnstone

According to a recent study by two WVU professors, anesthesia services and preoperative tests required by anesthesia providers account for 3 to 5 percent of total health care costs in the United States.

The study, "Costs of Anesthesia," which appeared in the March 31 edition of *Anesthesia and Analgesia,* was written by Dr. Robert E. Johnstone, professor of anesthesiology, and Cindy L. Martinec, Ph.D., assistant professor of management in the WVU College of Business. Drs. Johnstone and Martinec say these costs are not subject to normal market forces and that patients usually do not consider anesthesia costs in making decisions about surgery.

Moore named dean of School of Dentistry

Moore

Robert N. Moore, D.D.S., Ph.D., Ed.D., has been named dean of the School of Dentistry.

Dr. Moore, who was an associate professor of orthodontics at WVU from 1978 to 1983, is currently professor and chair of orthodontics at the University of Nebraska Medical Center, where he also directs the postgraduate program in orthodontics.

Obituary

George H. Wirtz, Ph.D., 61, a professor in the Department of Biochemistry, died of a heart attack Saturday, March 27. He had been employed at WVU for 30 years.

Where quality is affordable . . .

Participating
Dealer For
AMERINET,
SUNHEALTH,
and
VHA ACCESS

BEAUTIFUL OFFICE SUITES in easy to visualize arrangements featuring styles in TRADITIONAL, CONTEMPORARY, PERIOD and more. Enjoy the beauty of CHERRY, OAK, MAHOGANY and WALNUT. You'll find them all on our showroom floors.

CUSTOM OFFICE FURNITURE, INC.

1260 GREENBRIER ST. CHARLESTON, WV 25311

INTERIOR DESIGN SERVICE
SPACE PLANNING

PHONE 343-0103 or 1-800-734-2045
WV CONTRACTOR NO. WV008652

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Turnkey
Business Systems, Inc.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University

MU among top four schools in nation in number of FP grads

The School of Medicine received a Silver Achievement Award from the American Academy of Family Physicians on April 26 for being one of the top four schools in the United States in the percentage of graduates entering residencies in family practice.

Over the past three years, nearly 27 percent of Marshall's graduates have entered family practice residencies. The other two medical schools receiving Silver Achievement Awards were East Carolina University and the University of North Dakota. Only Mercer University exceeded the 30 percent level required for the gold award, and 10 schools received bronze awards for levels over 20 percent.

Dr. Robert B. Walker, chairman of the Department of Family and Community Health, said the award is especially gratifying because it recognizes concrete accomplishments.

"I feel particularly positive about this award because it focuses strictly on outcomes," Dr. Walker said. "Many schools have good intentions and many have good plans to emphasize primary care, but few have proven track records. Marshall has developed a national reputation for producing the desired educational outcomes. It is always wonderful to be recognized by our peers because they know how hard it is to produce results like these in this day and time," he added.

Dr. Daniel Peterson, assistant professor of family and community health at Marshall, accepted the award from AAFP President John M. Tudor at the annual meeting of the Society of Teachers of Family Medicine's annual meeting in San Diego. This is the second year the AAFP has given the Family Practice Percentage Awards, and last year MU won a bronze award through the program.

Underrepresented specialites popular with MU graduates

Preliminary figures show that approximately two-thirds of the students graduating this year from the School of Medicine will enter residencies in underrepresented specialties.

More than half of the graduates in this generalist group will enter residencies in family practice; the rest will go to programs in general internal medicine, pediatrics, obstetrics/gynecology, psychiatry and emergency medicine. Other graduates will enter fields as varied as surgery, anesthesiology, and radiology.

"We're particularly pleased with the number of people going into family practice and the other primary-care fields," said JoAnn Raines, academic affairs coordinator for the school of medicine. "We also have several students entering nationally prestigious residency programs. Brown University has accepted one of our graduates for the first time ever.

This year's graduating class includes the first participants in Marshall's accelerated family practice residency. Through this program, two seniors combined the last year of medical school with their first year of residency.

"This program has been quite successful for us and for the students," said Dr. Stephen Petrany, director of the family practice residency program. "It helped us keep two of our very best students here at Marshall for their residencies, and it will allow them to enter practice one year sooner. We hope that ultimately this program will encourage them to practice in West Virginia. Starting July 1, three rising seniors will begin the accelerated family practice residencies," he added.

Marshall's own programs also fared well in the residency matching process, Raines said. Despite intense national competition for residents in internal medicine, for example, Marshall filled its program and still had to turn away qualified applicants, she said.

Fix, Walker receive national, state honors

The National Medical School Review bestowed its Outstanding Professor Award to Dr. James D. Fix, professor of anatomy and cell biology, for his teaching in neuroanatomy. Dr. Fix directs the neuroscience course for the School of Medicine and has written a textbook on neuroanatomy, as well as a book on the human brain and spinal cord.

Another Marshall faculty member who was recently honored is Dr. Robert B. Walker, chairman of the Department of Family and Community Health. Common Cause West Virginia presented Dr. Walker with its Public Service Award for his efforts toward health care reform and his work in providing health care to the underserved.

Three students earn Research Day awards

Paul Holley, MSIV, Becki Sue Hill, MSIII, and graduate student William Todd Seaman were honored for their presentations at Marshall's sixth annual Research Day on March 9.

Holley won the best clinical science presentation award for "Adolescent Health Care and the Practicing Pediatrician in West Virginia;" Hill was honored for having the best clinical case study with "Presentation of Acute Intermittent Porphyria in the Psychiatric Setting;" and Seaman won the award for best basic science presentation with "Mutations Within the Leucine Zipper of the Transmembrane Protein (gP41) of HIV Interfere with Wild-Type Mediated Membrane Fusion."

This year's Research Day featured more than 50 scientific presentations from students, residents and faculty members. Dr. Erling Norrby, an internationally renowned virologist who serves on the Nobel Prize Committee, was the keynote speaker. Dr. Norrby collaborates in research with Dr. Maurice Mufson, chairman of medicine at Marshall.

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH

EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD

Specializing in
Head and Neck Cancer Surgery
Cosmetic Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

- **35-bed JCAHO Accredited Hospital**
- **Ambulatory Care/ Same Day Surgery**

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)

THE WHEELING CLINIC

WHEELING, WEST VIRGINIA 26003

Wheeling, 234-2000 • St. Clairsville, (614) 695-2511 • New Martinsville area, 455-2222 • Wellsburg-Steubenville area, 737-3700
Martins Ferry area, (614) 633-4557 • toll-free no. out of state, 1-800-245-8015

INTERNAL MEDICINE
General
D. J. Panucci, M.D.
P. R. Hedges, M. D.
R. N. Lewis, M. D. (St. Clairsville)

Peripheral Vascular Disease
J. D. Holloway, M. D.

Cardiovascular
A. M. Valentine, M. D.
W. E. Noble, M. D.

Rheumatology
R. Vawter, M. D.

GENERAL SURGERY
E. C. Voss, M. D.
G. Galvin, M. D.
E. Cohen, M. D.

UROLOGY
D. C. Trapp, M. D.

OPHTHALMOLOGY
R. V. Pangilinan, M. D.
D. Simbra, M. D.
H. F. Leeper, M. D., Ph.D.
Kathryn M. Clark, O. D.

OTOLARYNGOLOGY/ MAXILLO-FACIAL SURGERY
W. A. Tiu, M. D.
A. G. Matadar, M. D.

RADIOLOGY
Valley Radiologists, Inc.

FAMILY PRACTICE
G. L. Cholak, M. D. (St. Clairsville)
E. L. Coffield, M. D. (New Martinsville)
C. P. Entress, M. D.
T. H. Korthals, M. D. (St. Clairsville)
J. H. Mahan, M. D. (St. Clairsville)

PODIATRY
B. Blank, D.P.M. (St. Clairsville)

DERMATOLOGY
G. A. Ganzer, M. D.

NEUROLOGY
H. L. Kettler, M. D.

BEHAVIORAL MEDICINE
S. D. Ward, M. D. (Martins Ferry)
D. P. Hill, M. D. (Martins Ferry)
R. Paolini, D. O. (Martins Ferry)

ANCILLARY SERVICES
Optical
Speech Therapy/Audiology
Counseling/Group Therapy
Biofeedback Laboratory
Electrology/Cosmetic Therapy
Electrocardiography
Electroencephalography
Neurological Studies (Non-invasive)
Roentgenology
24° A/EEG Scanning Service
Cardiac Ultrasound
Clinical Laboratory

Auxiliary News

Auxiliary to introduce resolution to AMAA

During the past few months I've learned more than I ever wanted to know about politics and how a bill becomes a law. It's a tireless, thankless process, but one I think more people should become involved with.

The WVSMA Auxiliary can take pride in knowing we are one of the first auxiliaries in the country that has successfully lobbied for legislation and seen it pass. That legislation, HB 2024, which requires a statement on a marriage license application that each partner has the right to be free from violence and also explains the laws against domestic violence, passed both bodies during the last two days of the session.

Although it was a great accomplishment, we did not come by it easily. At times, it became a weary effort just to get senators and delegates to listen to our cause. In addition, the negative publicity that surrounded the bill at the beginning of the session did not help. Fortunately, several newspapers came out in favor of HB 2024, so we had enough positive support to combat the negative. Looking back, I am sure one of the reasons for our success was that several auxilians visited the State Capitol almost weekly to try to talk to as many legislators as possible about HB 2024. Many were not receptive to the idea, but the more we pushed awareness of domestic violence, the more people began to listen. I think, too, many legislators began to realize, with all our visits, phone calls, and personal letters, we were not going to give up. As I said before, it was very tiring, and it took a lot of effort, but it worked!! Beginning this fall, there will be a statement about domestic violence on all West Virginia marriage license applications.

In order to share our success with other auxiliaries around the country, the WVSMAA has introduced the following resolution on domestic violence which will be presented to the AMAA at the Annual Meeting in June:

WHEREAS, AS MANY AS FOUR MILLION WOMEN ARE PHYSICALLY BATTERED EACH YEAR BY HUSBANDS, EX-HUSBANDS AND BOYFRIENDS, MAKING DOMESTIC VIOLENCE THE SINGLE LARGEST CAUSE OF INJURY TO WOMEN IN THE UNITED STATES, AND

WHEREAS, FAMILY VIOLENCE HAS BEEN NAMED A MAJOR PUBLIC HEALTH THREAT BY THE CENTERS FOR DISEASE CONTROL, AND

WHEREAS, VIOLENCE TOUCHES AS MANY AS ONE-FOURTH OF ALL AMERICAN FAMILIES, AND

WHEREAS, DOMESTIC VIOLENCE IS NOT ONLY SEVERELY TRAUMATIZING TO THE VICTIMS, BUT DETRIMENTAL TO SOCIETY AS A WHOLE, AND

WHEREAS, THE AMERICAN MEDICAL ASSOCIATION LAUNCHED A NATIONAL CAMPAIGN AGAINST FAMILY VIOLENCE TO EDUCATE PHYSICIANS ABOUT FAMILY VIOLENCE AND HELP THEM ADDRESS THE PROBLEM IN THEIR COMMUNITIES, THEREFORE BE IT

RESOLVED, THAT THE AMERICAN MEDICAL ASSOCIATION AUXILIARY ENCOURAGE ITS STATE AND COUNTY AUXILIARIES TO ENCOURAGE THEIR LOCAL MEDICAL SOCIETIES AND ASSOCIATIONS TO SUPPORT AND DEVELOP LEGISLATION REQUIRING AN APPLICATION FOR A MARRIAGE LICENSE TO INCLUDE A STATEMENT ON DOMESTIC VIOLENCE.

Pacita Salon
WVSMAA President

Davis & Davis Accounting Services

602 Tennessee Avenue • Charleston, WV 25302
• 304-343-4656 • 800-281-4572 • FAX 304-343-4657

Davis and Davis Accounting provides efficient electronic medical billing to help you receive faster reimbursement. We can bill insurance companies daily, weekly, monthly and/or on demand. As a result of prompt billing, the turnaround time on your reimbursement claims can be reduced by as much as 30 days.

We provide:

- filing of all primary and secondary insurance claims
- patient billing - as lump sum or budget payments
- collections - open line posting, follow up letter on late payments, problem accounts (three letters and turn over for collection)

Billing System equipped with:

- line error checking
- account aging
- cycle billing capablilities
- open line posting
- custom reports tailored to you individual practice

HEALTHTALK™

ICN is proud to offer **HEALTHTALK™** to the medical community of West Virginia. This exclusive program was designed to show our appreciation to the many individuals that have contributed to the health and welfare of the residents of West Virginia. To learn more about the special benefits **HEALTHTALK™** members enjoy, please call your local ICN office.

INDEPENDENT CELLULAR NETWORK
a Wireless One Network company

CHARLESTON	LOGAN	HUNTINGTON	WHEELING	PARKERSBURG
925-4000	752-5200	525-4101	233-5600	485-5600

THE MYERS CLINIC — Philippi, West Virginia

Notice: Seeking Internal Medicine, Pediatrics, and/or Family Practice, must be Board Certified or Board Eligible.

Contact: Lonnie L. Crane, 112 North Woods Street, Philippi, WV 26416. 1-(304) 457-2800

Radiology:
Halberto G. Cruz, M. D.

Pathology:
Fulvio Franyutti, M. D.

Surgery:
J. W. Woodford, M. D.

Pediatrics:
E. G. Kreider, M. D.

Internal Medicine:
Karl J. Myers, Jr., M. D.
Z. Moussa, M. D.

New Members

We would like to welcome these new members to the WVSMA:

Daniel B. Thistlethwaite, M.D.
P.O. Box 3546
Charleston, WV 25335-3546

Steven L. McCormick, M.D.
3100 MacCorkle Avenue
Charleston, WV 25304

Farouk Abadir, M.D.
2828 1st Avenue
Suite 301
Huntington, WV 25702

Michael DeWitt, D.O.
4605 MacCorkle Avenue
South Charleston, WV 25309

Charles Jacques, M.D.
1201 Washington Street E.
Suite 108
Charleston, WV 25301

Osterman Cotes, M.D.
401 Division Street
South Charleston, WV 25309

Michael A. Krasnow, D.O.
1115 Hal Greer Blvd.
Huntington, WV 25701

Janet Vondran, M.D.
304 Seneca Trail
Ronceverte, WV 24970

Michael Kinney
WVU School of Medicine
Morgantown, WV 26506

WHEN YOU CAN'T BREATHE, NOTHING ELSE MATTERS®

For information about lung disease such as asthma, tuberculosis, and emphysema, contact your local Lung Association

AMERICAN LUNG ASSOCIATION.

WESPAC Members

We would like to thank the following physicians and auxilians for their recent contributions to WESPAC:

Physicians

Boone
Ernesto T. Yutiamco

Brooke
William T. Booher Jr.

Cabell
*J.A. Cochrane

Central
Stephen M. Smith
*Rigoberto R. Ramirez

Eastern
Michael Strider
Harvey Reisenweber

Fayette
Enrique Aguilar

Greenbrier
Douglas Jones

Harrison
Chinmay K. Datta
Frank C. Gyimesi
Erlinda L. De La Pena

Hancock
Karen M. Gross

Kanawha
**Samuel R. Davis
*Michael Fidler
Rodney L. Hall
Jimmie L. Mangus
*Cecilio V. Delgra
**Ronny H. Go
*Ralph Smith
*Ronald L. Wilkinson
*Mickey J. Neal
*Fred T. Pulido Jr.

Logan
*Harry D. Fortner
Livia N. Cabauaton

Marshall
*Kenneth J. Allen
Howard Neiberg

Mason
Ismael O. Jamora
**John A. Wade Jr.

Mercer
*Generoso Duremdes
*Tilman K. Edwards

Monongalia
*Richard S. Kerr
*Stephen L. Sebert

Ohio
Jaywant P. Parmar
Byron L. Van Pelt

Parkersburg
Richard E. Johns
Loretto R. Auvil
Alfred Prieto

Raleigh
*Donald L. Rasmussen
Mousa I. Dababnah

Ohio
*Harry Weeks Jr.
*Larry Dodd

Western
Rogelio A. Averion
Herminio L. Gamponia
Pedro F. Lo

Auxilians

Ohio
*Esther Weeks

Obituary

Frank Jackson Holroyd, M.D.

Dr. Frank J. Holroyd, 86, of Princeton, died April 10 at home.

A native of Athens, W.Va., Dr. Holroyd received an A.B. degree from Concord College, a B.S. degree from West Virginia University, and his medical degree from the University of Maryland in 1929. He interned at the U.S. Naval Hospital in Baltimore, Md., and then did his residency at the former Princeton Hospital and became the city health officer for Princeton.

Following his residency, Dr. Holroyd completed postgraduate studies in internal medicine and cardiology at New York Hospital, Harvard University Hospital and Barnes Hospital in St. Louis. He then opened his practice in internal medicine in Princeton in 1934, and cared for patients for 58 years.

Very active in organized medicine on a national, state and local basis during his career, Dr. Holroyd was the longest serving delegate of the American Medical Association and also acted as campaign manager for the AMA's 1970-71 presidential elections. In 1952, the AMA presented Dr. Holroyd with a plaque in highest recognition and honor of his distinguished service and dedicated work against socialized medicine. He was president of the WVSMA in 1951, served two terms on Council, was a former chairman of the Legislative Committee, and was the first chairman of the WESPAC Committee. In addition, he was chairman of the West Virginia State Medical Licensing Board for 36 years, and was a past president and secretary of the Mercer County Medical Society.

Instrumental in the formation of the Mercer County Health Department, Dr. Holroyd was also chief of staff at Princeton Memorial Hospital and Princeton Community Hospital. He was a life member of the American Academy of Physicians and the American Academy of Family Physicians.

Holroyd

Devoted to the Princeton community, Dr. Holroyd was a member of First United Methodist Church and the Princeton-Athens Kiwanis Club, and served on the board of directors of First Community Bank. He helped to found the Princeton Boosters Club and was awarded the Silver Beaver Award for his work with the Boy Scouts of America.

Surviving are his wife, Mary Thomas Holroyd; sons, Frank J. "Jack" of Sarasota, Fla., Frederick F. II of Charleston, and Robert E. of Princeton; daughter, Diana Holroyd of Reston, Va.; 13 grandchildren; and nine great-grandchildren.

In Dr. Holroyd's memory, Mrs. Holroyd has established memorial scholarship funds at both First Baptist Church and First United Methodist Church in Princeton. Scholarships will be awarded by committees from each church to deserving students who wish to pursue careers in health care. Anyone wishing to donate to this fund should mail their contributions to either First Baptist Church, 1116 Mercer Street, Princeton, WV 24740 or First United Methodist Church, P.O. Box 304, Princeton, WV 24740.

"I never forget what it means to be a doctor, and what it means is embodied in the American Medical Association Principles of Medical Ethics."

Dr. Aliza Lifshitz
Los Angeles, California

Bringing medical care to illegal aliens and the underprivileged in Southern California. That's how Dr. Lifshitz acts upon her belief in the American Medical Association Principles of Medical Ethics, the cornerstone of our profession.

You are invited to join with Dr. Lifshitz in her efforts to bring quality health care to those in need. You are invited to join the American Medical Association.

Members of the AMA are encouraged to join their state, county, and specialty societies.

American Medical Association
Physicians dedicated to the health of America

WILLIAM C MORGAN, Jr., M.D., F.A.C.S.
Otologist
Diplomate, American Board of Otolaryngology

OTOLOGY: DISEASES & SURGERY OF THE EAR

Sheri L. Jeffries
Audiologist

304-345-7100

Complete Audiological Services • Hearing Aid Dispensing & Service
Assistive Listening Devices • Electronystagmography • ABR

ST. FRANCIS MEDICAL PLAZA • 331 LAIDLEY STREET, SUITE 602 • CHARLESTON, WV 25301

Make your birthmarks disappear.

Certified By: American Board of Plastic Surgery
Fellow of the American College of Surgeons
Fellow of the Royal College of Surgeons (Canada)

Now there's a safer and more effective treatment for red vascular birthmarks

Fast . . . F.D.A. Approved . . . Near your hometown.

With our new Candela Vascular Lesion Laser, we can now treat birthmarks like Port Wine Stains and other red blemishes including small facial veins . . . effectively and with minimal discomfort.

- The latest in medical laser technology. This method has been approved by the F.D.A. and has been proven safe for children and infants.
- No surgery required.
- Treatments are done right in the office without a hospital stay.

Learn how you can make birthmarks disappear.
Call for a free consultation appointment:

1-800-628-6748

LAWRENCE W. TARRANT, M.D.

ASSOCIATES IN OBSTETRICS AND GYNECOLOGY

OFFERING PERSONALIZED CARE 24 HOURS A DAY 7 DAYS A WEEK
FOR OBSTETRICAL & GYNECOLOGICAL EMERGENCIES & FOR INFANT DELIVERY

OUTPATIENT & OFFICE SURGERY

9 MEMBER GROUP OF OB-GYN SPECIALISTS

CHARLES W. MERRITT, M.D.
ROBERT P. PULLIAM, M.D.
OWEN C. MEADOWS, M.D.
MICHAEL T. WEBB, M.D.
ANGEL L. ROSAS, M.D.
NANCY R. WEBB, M.D.
NORMAN W. TAYLOR, M.D.
WILLIAM A. SCARING, M.D.
NORMAN L. SIEGEL, M.D.

- CONTRACEPTIVE COUNSELING
- ARTIFICIAL INSEMINATION
- UROLOGICAL EVALUATIONS & TREATMENT
- INFERTILITY EVALUATIONS
- BREAST SCREENING

255-1541

410 CARRIAGE DR. BECKLEY

EDITOR
Stephen D. Ward, M. D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M. D., Charleston
Joe N. Jarrett, M. D., Oak Hill
Robert J. Marshall, M. D., Huntington
David Z. Morgan, M. D., Morgantown
Louis C. Palmer, M. D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M. D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to The West Virginia Medical Journal, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Scientific Newsfront

Video-assisted thoracoscopy: A major advance in diagnosis and treatment of intrathoracic pathology
Gerald G. Tanguilig, MSII; David R. Jones, M.D.; and Geoffrey M. Graeber, M.D., F.A.C.S. 230

The chemohormonal therapy of metastatic melanoma: Possible benefit of tamoxifen
Edward B. Crowell Jr., M.D., F.A.C.P.; and Gerald M. Higa, Pharm. D. 233

New Manuscript Guidelines 235

Cystic fibrosis: Current concepts
Medical Grand Rounds from West Virginia University Health Sciences Center, Edited by Irma H. Ullrich, M.D.
Henry L. Abrons, M.D. (Discussant) 236

President's Page

Policies! 242

Editorial

Circling buzzards 243

In My Opinion

OMA offers physicians a means of survival 244

Our Readers Speak

Comparison of infant mortality rates meaningless 244

Special Departments

General News 248
Continuing Medical Education 254
Medical Meetings/Poetry Corner 255
Bureau of Public Health News 256
WVU Health Sciences Center News 258
MU School of Medicine News 260
Obituary/Society News 262
Classified 265
June Advertisers 266

Front Cover

A turtle gazes at the greenery at Kanawha State Forest near Charleston. Photo courtesy of *Robbie Parsons,* South Charleston, W.Va.

Video-assisted thoracoscopy: A major advance in diagnosis and treatment of intrathoracic pathology

GERALD G. TANGUILIG, MSII
DAVID R. JONES, M.D.
GEOFFREY M. GRAEBER, M.D., F.A.C.S.
Department of Surgery, West Virginia University, Morgantown

Abstract

The diagnosis and treatment of intrathoracic disease often requires open thoracotomy. Patients who are immunocompromised, have poor pulmonary function, or have coronary artery disease may not tolerate this procedure well. With the advent of small video cameras, fiberoptics, and compatible instrumentation, thoracoscopy is now a viable option to open thoracotomy. This procedure is being performed with increasing frequency, and has achieved excellent results. The intrathoracic image, which previously was only available to the operating surgeon, is captured by a small video camera on the end of the scope. The image is projected simultaneously on several television monitors in the operative suite so that all members of the operative team can see exactly what the surgeon sees. By using such technologies, intrathoracic diagnostic and therapeutic procedures, which previously required some type of open thoracotomy, may now be performed through several small ports placed through diminutive surgical incisions. This article describes three case reports which demonstrate some of the successful applications of video-assisted thoracoscopy, and reviews the diagnostic and therapeutic indications for video-assisted thoracoscopy.

Introduction

Thoracoscopy was introduced by Jacobaeus (1) over 80 years ago for the diagnosis and treatment of patients with tuberculosis. Using a modified cystoscope, he lysed adhesions between the pleura and chest wall to facilitate creation of a pneumothorax to treat tuberculosis and called this procedure pneumolysis.

Video-assisted thoracoscopy is a procedure which utilizes a tubular optical device, the thoracoscope, which is inserted into the hemithorax through a small intercostal incision. Through the thoracoscope the surgical team can examine the chest wall, pleura, lungs, mediastinum, and diaphragm and have the continuous video image displayed on multiple monitors in the surgical suite. Surgical exploration of the chest can be performed, therefore, through a very limited incision, rather than through the standard thoracotomy incision.

With the advent of antitubercular medications, however, thoracoscopy usage tapered. In the past 25 years, the diagnostic and therapeutic use of thoracoscopy has increased. The confining view of the thoracoscope (which may be compared to looking through a keyhole) restricted the efficacy and application of thoracoscopy, often excluding those assisting the surgeon from viewing the thorax (2). With the introduction of video cameras and fiberoptics, all members of the surgical team can participate in the surgical procedure since the image is presented on several television monitors at the same time. The superior visualization of the thorax, afforded by video-assisted thoracoscopy, has expanded both diagnostic and therapeutic applications of the procedure.

Thoracoscopy technique

To begin performing thoracoscopy, the patient is placed under general anesthesia with a double-lumen endotracheal tube which allows for selective lung ventilation. The patient is then positioned in the standard posterolateral thoracotomy position on the operating table.

The ipsilateral lung is collapsed by the anesthesiologist, and a 3-cm. incision is made along the fifth intercostal space in the midaxillary line to allow introduction of the thoracoscope. Two more small incisions are made in the anterior and

Table 1. Diagnostic Indications for Thoracoscopy

PLEURA	Idiopathic Pleural Effusions Pleural Thickening/Fibrosis Empyema Pneumothorax Traumatic or Spontaneous Hemothoraces Pleural Tumor
LUNG	Diffuse Pulmonary Disease Bronchogenic Carcinoma/Clinical Staging "Coin" Lesions Hormone Receptor Determination Traumatic Lung Injury
MEDIASTINUM	Suspected Absence of Left Pericardium Suspected Cardiac Herniation Congenital Anomalies of the Heart and Great Vessels Biopsy of Mediastinal Tumors Biopsy of Mediastinal Lymph Nodes
CHEST WALL	Malignant Tumor Invasion
DIAPHRAGM	Traumatic Injury Diaphragmatic Hernias

Table 2. Therapeutic Indications for Thoracoscopy

PLEURA	Pleural Effusion -chemical/talc pleurodesis -Nd:YAG laser vaporization Pneumothoraces -electrocautery or CO_2 laser -blebectomy and pleurectomy -chemical/talc pleurodesis Empyema -debridement -exact placement of closed-tube thoracostomies Malignant Mesotheliomas -pleurectomy -laser vaporization Foreign Body Removal Hemothorax -clot evacuation -diathermy
LUNG	Bullous Emphysema -CO_2 laser ablation Lung Tumors -wedge resection -segmental resection -lobectomy
MEDIASTINUM	Malignant Pericardium/Pericarditis -partial pericardiectomy Mediastinal Cyst/Goiter -resection
CHEST WALL	Bleeding Intercostal Vessels -electrocoagulation
INTRATHORACIC NERVES	Causalgia or Hyperhidrosis -sympathectomy Vagectomy
ESOPHAGUS	Achalasia -Heller Myotomy Diffuse Spasm -Long Myotomy

posterior axillary lines under direct thoracoscopic visualization for the insertion of endoscopic ports through which forceps, scissors, stapling devices, etc. may be placed. These two incisions are made along the same intercostal space as the first in case a formal thoracotomy is needed. The triangulation of ports provides excellent exposure to the hemithorax and allows access to all structures contained within that pleural space plus the ipsilateral side of the mediastinum.

After completion of the intended procedure, a chest tube is inserted under direct visualization, through the anterior port. The remaining ports are then removed, and the incisions closed primarily. The patient is extubated intraoperatively and transferred to their room after recovery from the anesthetic.

Diagnostic indications

Since its inception, thoracoscopy has been helpful in the diagnosis of diseases of the pleura (Table 1). Pleural effusion represents one of the most common indications for diagnostic thoracoscopy (3-7).

In the case of pleural effusions related to metastatic breast cancer, thoracoscopy may provide suitable tissue for estrogen-binding assays (7-8). Other conditions which may warrant thoracoscopic examination and biopsy of the pleura include pleural thickening (5), pleural-based tumor (3-4), and empyema (4). Allowing visualization of the lung and pleura, thoracoscopy has a much higher rate of diagnostic accuracy for pleural pathology than blind-needle biopsy (4). Pneumothorax (3,4), spontaneous hemothorax (9), and traumatic hemothorax (4,10,11) may also be assessed by thoracoscopy.

Lung parenchymal diseases are often diagnosed via thoracoscopy. Several authors report using diagnostic thoracoscopy for lung biopsy in patients with diffuse pulmonary disease (4,12,13). The use of stapling devices compatible with the thoracoscopic ports simplifies the securing of adequate biopsy material (13). Thoracoscopy is also useful for diagnosing bronchogenic carcinoma and in determining its clinical stage (3,4,10). Some investigators have used thoracoscopy to evaluate traumatic lung injuries (4).

In addition, the application of thoracoscopy has been extended to the mediastinum. Wakabayaski (14) reports that thoracoscopic biopsy of aorticopulmonary window and pulmonary ligament lymph nodes is possible, thereby negating the need for open thoracotomy or mediastinoscopy. Thoracoscopy has also been used to biopsy mediastinal tumors (11) and to diagnose congenital anomalies of the heart and great vessels (8). In two special cases, thoracoscopy has been used to confirm suspected cardiac herniation subsequent to radical pneumonectomy (15) and suspected congenital absence of the left pericardium (16).

The chest wall and diaphragm are two other anatomical sites that often require diagnostic procedures. Weissberg and Kaufman report using thoracoscopy to determine chest wall penetration by a malignant lung tumor (4); and this technique has been used to identify and diagnose the chest wall bleeding source, to assess diaphragmatic injury following chest trauma, and to diagnose diaphragmatic hernias (4,10) (Table 1).

Therapeutic indications

Pleural pathology can be definitively treated with thoracoscopic techniques (Table 2).

The treatment of pleural effusions, malignant or benign, has been approached by chemical pleurodesis (5,19), talc pleurodesis (4,6,20), and Nd:YAG laser vaporization (14). Therapeutic thoracoscopy has also been extensively applied to pneumothoraces. Wakabayashi introduced electrocautery and carbon dioxide laser pleural ablation for spontaneous pneumothoraces (14). Nathanson described treatment of recurrent spontaneous pneumothoraces with blebectomy and pleurectomy (20). Debridement and removal of the pleural peel has been successful in cases of thoracic empyema (14,19,22). In addition, foreign body removal (19) and evacuation of hemothoraces (9,10,11) can safely be accomplished with the thoracoscope.

Lung parenchymal diseases may be treated without need for open thoracotomy. Wedge resection of metastatic lung cancer, formal lobectomies, and resections for benign tumors have all been done through the thorascope (14,23).

In the mediastinum, cysts (2) and goiters (14) have been removed thoracoscopically. Partial pericardiectomy for malignancy or pericarditis (14) and creation of pericardial windows have been reported (24). Bleeding intercostal vessels have been electrocoagulated thoracoscopically (4). Lastly, sympathectomies have been performed by thoracoscopy for such conditions as causalgia and hyperhidrosis (11,12) (Table 2).

Case reports

First patient

A 56-year-old gentleman with no history of any tobacco use or exposure to asbestos had an eight-month history of progressive dyspnea on exertion. Serial chest radiographs showed a worsening pulmonary interstitial process. Cardiac evaluation was unremarkable, but, preoperative pulmonary function tests showed a moderate restrictive pattern.

He underwent video-assisted thoracoscopy and had lung biopsies obtained from his right upper and middle lobes. One chest tube was placed intraoperatively and was removed on postoperative day (POD) two.

This patient was discharged 72 hours after admission. Pathologic examination of the lung parenchyma specimen showed sarcoidosis and he was treated accordingly.

Second patient

A 39-year-old female with no history of chest trauma came to the Family Practice Clinic at West Virginia University with complaints of pain in her left-lateral chest wall. She was treated with non-steroidal anti-inflammatory agents for a presumed diagnosis of costochondritis.

Persistent pain and new onset of dyspnea with exertion prompted a return to the clinic where a chest X-ray showed a left pneumothorax. Left-closed tube thoracostomy was performed with complete re-expansion of the lung. The chest tube was removed and the patient was discharged.

Three weeks later, the patient again presented with complaints of pain in her left chest wall. A recurrent left spontaneous pneumothorax was diagnosed radiographically. She underwent thoracoscopic blebectomy and mechanical pleurodesis. Her chest tubes were removed on POD #2 and she was discharged on POD #4 with total re-expansion of her lung.

Third patient

A 27-year-old female with a history of a right spontaneous pneumothorax had been treated successfully with closed-tube thoracostomy. One month after this hospitalization, she again experienced right chest pain in the absence of dyspnea, and a second closed-tube thoracostomy was placed for recurrent spontaneous pneumothorax.

This patient then underwent video-assisted thoracoscopic evaluation of her right pleural space. No definitive bullae or blebs were identified, and she had thoracoscopic mechanical pleurodesis performed without incident. She developed a small postoperative air leak which necessitated continued closed-tube thoracostomy until POD #4, but she was discharged shortly thereafter.

Summary

Video-assisted thoracoscopy has diagnostic as well as therapeutic indications. In our experience, it has become the technique of choice for many procedures which used to necessitate open thoracotomy. Length of hospitalization, patient morbidity, and overall cost appear to be decreased when video-assisted thoracoscopy is employed; and we have found this technique to be safe, effective, and well-tolerated even by patients with advanced disease processes.

Under certain circumstances, the chest may have to be opened and the operation completed in traditional fashion. For this reason, it is recommended that thoracoscopy only be performed by trained thoracic surgeons.

The future use of video-assisted thoracoscopic procedures appears bright since new instruments are constantly being developed. Thoracic surgeons continue to expand the list of intrathoracic procedures which may be completed successfully by employing this new technique.

Acknowledgements

The authors wish to express their gratitude to Joyce A. Elias for her excellent preparation of this manuscript.

References

1. Jacobaeus HC. Ueber die Möglichkeit die Zystoskopie bei untersuchung Seröser hohlungen anzuwenden. Munchen Med Wochenschr 1910;57:2090-2.
2. Lewis RJ, Caccavle RJ, Sisler GE. Imaged thoracoscopic surgery: a new thoracic technique for resection of mediastinal cysts. Ann Thorac Surg 1992;53:318-20.
3. Oldenburg FA, Newhouse MT. Thoracoscopy: a safe, accurate diagnostic procedure using the rigid thoracoscope and local anesthesia. Chest 1979;75:45-50.
4. Weissberg D, Kaufman M. Diagnostic and therapeutic pleuroscopy: experience with 127 patients. Chest 1980;78:732-5.
5. Page RD, Jeffrey RR, Donnelly RJ. Thoracoscopy: a review of 121 consecutive surgical procedures. Ann Thorac Surg 1989;48:66-8.
6. Cantó A. Macroscopic characteristics of pleural metastases arising from the breast and observed by diagnostic thoracoscopy. Am Rev Respir Dis 1990;142:616-8.
7. Newhouse MT. Thoracoscopy: diagnostic and therapeutic indications. Pneumologie 1989;43:48-52.
8. Bloomberg AE. Thoracoscopy in perspective. Surg Gynec Obstet 1978;147:433-43.
9. Dimitri WR. Massive idiopathic spontaneous haemothorax: case report and literature review. Eur J Cardio-thorac Surg 1987;1:55-8.
10. Jones JW, Kitahama A, Webb WR, McSwain N. Emergency thoracoscopy: a logical approach to chest trauma management. J Trauma 1981;21:280-4.
11. Radigan LR, Glover JL. Thoracoscopy. Surgery 1977;82:425-8.
12. Dijkman JH, ver der Meer JWM, Bakker W, Wever AMJ, van der Broek PJ. Transpleural lung biopsy by the thoracoscopic route in patients with diffuse interstitial pulmonary disease. Chest 1982;82:76-83.
13. O'Riordan BG, Dainel FJ, Fletcher DR. Open lung biopsy without thoracotomy: technique and possible indications. Aust NZ J Surg 1992;62:79-80.
14. Wakabayashi A. Expanded applications of diagnostic and therapeutic thoracoscopy. J Thorac Cardiovasc Surg 1991;102:721-3.
15. Rodgers BM, Moulder PV, DeLaney A. Thoracoscopy: new method of early diagnosis of cardiac herniation. J Thorac Cardiovasc Surg 1979;78:623-5.
16. Gehlmann HR, van Ingen GJ. Symptomatic congenital complete absence of the left pericardium. Case report and review of the literature. Eur Heart J 1989;10:670-5.
17. Adamthwaite DN. Traumatic diaphragmatic hernia. Surg Annu 1983;15:73-97.
18. Adamthwaite DN. Diaphragmatic hernia presenting itself as a surgical emergency. Injury 1984;15:367-9.
19. Oakes DD, Sherck JP, Brodsky JB, Mark JBD. Therapeutic thoracoscopy. J Thorac Cardiovasc Surg 1984;87:269-73.
20. Daniel TM, Tribble CG, Rodgers BM. Thoracoscopy and talc poudrage for pneumothoraces and effusions. Ann Thorac Surg 1990;50:186-9.
21. Nathanson LK, Shimi SM, Wood RAB, Cuschieri A. Videothoracoscopic ligation of bullae and pleurectomy for spontaneous pneumothorax. Ann Thorac Surg 1991; 52:316-9.
22. Ridley PD, Braimbridge MV. Thoracoscopic debridement and pleural irrigation in the management of empyema thoracis. Ann Thorac Surg 1991;51:461-4.
23. Lewis RJ, Sisler GE, Caccavale RJ. Imaged thoracic lobectomy: should it be done? Ann Thorac Surg 1992;54:80-3.
24. Lewis RJ, Caccavale RJ, Sisler GE. Special report: video-endoscopic thoracic surgery. NJ Med 1991;88:473-5.

The chemohormonal therapy of metastatic melanoma: Possible benefit of tamoxifen

EDWARD B. CROWELL JR., M.D., F.A.C.P., *Associate Professor of Medicine, Mary Babb Randolph Cancer Center, West Virginia University School of Medicine, Morgantown*

GERALD M. HIGA, Pharm. D. *Assistant Professor of Clinical Pharmacy, Mary Babb Randolph Cancer Center, West Virginia University Schools of Medicine and Pharmacy, Morgantown*

Abstract

Metastatic melanoma is difficult to treat because of low response rates to most chemotherapy regimens and short remission durations. Recently, a new chemohormonal regimen containing BCNU, cisplatin, DTIC and tamoxifen (BCDT) has been reported to be more promising. We have treated eight patients with this regimen and five patients responded, including three with complete responses (CR). One of these patients remains in CR beyond two years. Others have also reported response rates of 50% with this regimen with a few long-term remissions also. Two of our patients developed deep venous thromboses (DVT). The increased incidence of DVT with BCDT is attributed to the tamoxifen, which nevertheless appears to be a necessary component of this regimen. In two of our patients, short courses of tamoxifen were used and they both obtained responses (one CR, one PR) without DVT. The possibility of using short-course tamoxifen to reduce the incidence of DVT in this regimen, without impairing its efficacy, should be investigated.

Introduction

The medical management of patients with metastatic melanoma has been disappointing, primarily because of a poor response to chemotherapy. Single agent and combination chemotherapy can produce overall objective response rates of up to 30%, but the duration of response is often brief (1). Recently, a chemohormonal regimen (BCDT) which includes carmustine (BCNU, BiCNU®), cisplatin (Platinol®), dacarbazine (DTIC, DTIC-Dome®) and the anti-estrogenic compound, tamoxifen (TAM, Nolvadex®), has produced overall response rates consistently around 50% (1-3). Although an improvement in overall survival has not yet been demonstrated, some patients have had durable complete remissions (1). Interestingly, TAM, which has very little effect when used alone in melanoma, seems essential in achieving the higher response rate in this regimen (3).

The object of this report is to present our experience using the BCDT regimen in patients with metastatic melanoma, and briefly review the role of TAM in this disease.

Patients and methods

Patient population

Eight consecutive patients (four men and four women) with histologically-confirmed melanoma and measurable or evaluable metastatic disease began treatment with BCDT between June 1990 and August 1992. Age, sites of metastases and prior therapy are shown in Table 1. All patients had adequate bone marrow function (WBC > 3,500/mm.^{3} and platelet count > 100,000/mm.^{3}) and renal function (measured creatinine clearance > 60 ml./min.) prior to initiation of therapy.

Treatment

All intravenous chemotherapy was administered in an inpatient setting. The patients were hydrated with two liters of 0.45% or 0.9% saline with supplemental KCl and $MgSO_4$ prior to chemotherapy. Maintenance intravenous fluids continued at 125 to 150 ml./hr. until discharge. Supplemental furosemide (Lasix®) was necessary in all patients to maintain adequate urine output. Combination antiemetics consisting of ondansetron (Zofran®), dexamethasone (Decadron®) and lorazepam (Ativan®) were routinely used.

A single cycle of the BCDT regimen consisted of BCNU 150 mgs./M^2 IV on day one only, cisplatin 25 mgs./M^2 IV and DTIC 220 mgs./M^2 IV on days one to three and 21-23, repeated every six weeks. TAM 10 mgs. orally twice a day was given continuously.

Responses were defined as follows: Complete response (CR) meant the disappearance of all evidence of disease; partial response (PR) meant a greater than 50% decrease in measurable disease or a definite decrease in evaluable disease (e.g. pleural effusion or peripheral edema) without any progression of disease in other areas; and mixed response (MR) meant definite evidence of response in some areas but progression of disease in other areas. The overall response rate was calculated using only those patients who achieved a CR or PR.

Results

As of November 20, 1992, eight patients received a total of 26 cycles of BCDT; with seven of the eight patients completing at least two cycles. Table 1 shows the type and duration of response and the survival from initiation of chemotherapy.

There have been three CRs and two PRs for an overall response rate of 63%. The three women (numbers 1, 5 and 8 in Table 1) with CR achieved that status after one, one and two cycles of therapy, respectively. Patient # 1, who has been in CR over two years and patient # 8, continue on therapy. Therapy was continued for patient # 5 for two cycles after she achieved a CR and was then stopped. Patient # 5 inadvertently received TAM for only the first three days of her first cycle. Since her disease was responding to therapy, she was subsequently given TAM for five days only every three weeks, beginning with the first day of chemotherapy. This schedule was then employed in patient # 7 also.

Patients # 2 and # 7 both achieved a PR. Patient # 2 had significant regression of lymph nodes in previously irradiated areas and complete resolution of edema and pleural effusion which lasted four months while he received chemotherapy. Marked decrease in node size and pleural effusion were seen after one cycle of BCDT in patient # 7, which also lasted until she developed bone metastases five months later.

Table 1. Patient Characteristics and Response to Therapy

NO.	SEX	AGE	SITES OF INVOLVEMENT	PRIOR THERAPY	RESPONSE	RESPONSE DURATION (MONTHS)	SURVIVAL (MONTHS)*	STATUS
1	F	71	N, SC, L, K	IFN	CR	26+	28+	A
2	M	24	N, S, L, H, B	IL-2, IFN, RT	PR	4	9	D
3	M	54	SC, S, H, B, BR, P		MR		8	D
4	M	50	N, SC, L, H		MR		2.5	D
5	F	72	N, SC, L	IFN	CR	8+	10+	A
6	M	60	N, S, L, H, BR		MR		9+	A
7	F	68	N, L		PR	5+	6+	A
8	F	44	N		CR	1+	4+	A

Abbreviations: N=Nodes; SC=Subcutaneous; S=Spleen, L=Lungs; H=Hepatic; K=Kidney; B=Bone; BR=Brain; P=Pleura; IFN=Interferon; IL-2=Interleukin-2; RT=Radiotherapy; CR=Complete response; PR=Partial response; MR=Mixed response; A=Alive; D=Dead

* From onset of chemotherapy

Mixed responses occurred in three men (patients # 3, 4 and 6), two of whom had liver involvement at the time of starting therapy. Although partial regression, primarily in subcutaneous nodules, occurred in patients # 3 and # 4 after one cycle of therapy, the disease continued to progress in the liver of patient # 3 and the lung of patient # 4. Despite objective improvement of his liver and lung lesions after two cycles, patient # 6 had progression of his brain and splenic metastases.

Therapy with BCDT was generally well tolerated. There were no episodes of fever with neutropenia or mucositis. Two patients received supportive G-CSF (Neupogen®) therapy; and two patients developed renal dysfunction requiring dose adjustment or discontinuation of cisplatin. The most frequent hematologic toxicity was thrombocytopenia, often necessitating delay of chemotherapy. However, only one patient required platelet transfusions. Patients # 1 and # 3, who were on continuous TAM therapy, developed deep venous thrombosis during chemotherapy, but patient # 1 had a history of phlebitis in the legs.

Discussion

Del Prete and colleagues (2) first reported that a combination chemohormonal regimen containing TAM (BCDT) produced a 55% overall response rate in metastatic melanoma. Other subsequent reports have shown similar overall response rates (1,3) and our rate of 63% is also consistent with this figure. Though randomized studies have not been done, the response rate to BCDT appears to be consistently higher than that reported with other chemotherapy combinations (1). Our first patient continues in CR beyond two years. McClay and colleagues (3) reported that two of their patients continued in CR for over five years, and, therefore, some patients with metastatic melanoma may be able to achieve durable complete remissions with the BCDT regimen.

The use of TAM to treat melanoma has seemed reasonable in view of observations suggesting that female hormones influence melanoma growth. These observations include the rarity of the disease before puberty, the adverse effect of pregnancy on stage II disease, and the reports of estrogen binding by melanoma cells (6). However, the presence of estrogen receptors in melanoma may be an artifact produced by the action of tyrosinase (an enzyme unique to pigmented cells) on estradiol (7). Further complicating the issue, is the fact that Gill and colleagues (8) have shown that estrogens, progesterone and TAM may both stimulate and inhibit the growth of human melanoma cells *in vitro*. Despite tumor regression in a few patients treated with TAM (4,5), most clinical studies have shown little or no effect of this drug when used alone in melanoma (6).

In view of the uncertainty of the role of TAM in treating melanoma and its potential thrombogenic effect, McClay and fellow authors evaluated the effect of TAM in the BCDT regimen. Ten of their 20 patients treated with the BCDT regimen achieved significant responses, including three with CR. However, because six of their patients developed deep venous thromboses (DVT), they omitted TAM from the next 20 patients they treated. Of these, only two patients (10%) achieved remissions (one CR and one PR). However, there were no thromboembolic events. They then treated an additional 25 patients with the combination containing TAM and again achieved an overall response rate of 52%, supporting the importance of TAM in the BCDT regimen.

Since TAM alone produces few responses, its apparent contribution to the BCDT regimen is thought to be a potentiating effect on one or more of the chemotherapy agents used. *In vitro* studies have demonstrated that TAM enhances cisplatin's effect (9). In a randomized clinical study, Cocconi and fellow authors (10) showed an increased response rate of DTIC plus TAM (28%), compared to DTIC alone (10%), but the overall response rate in this study was not as high as seen in the BCDT regimen. In another study, combining TAM with high-dose cisplatin and DTIC, Buzaid et al (11) reported only a 13% overall response rate. In view of the much lower overall response rate, these investigators suggested that TAM may be potentiating BCNU in the BCDT regimen. At present, it appears that all four drugs in the BCDT regimen are necessary for achieving the high overall response rate.

Two of our patients with CR and one with PR had received interferon-alpha (IFN-a, Roferon-A®) prior to BCDT. When used alone in metastatic melanoma, there is only about a 13% response rate to IFN-a (1), but there is a report that the use of IFN-a with DTIC produced a response rate of 53% (10). Although several weeks

elapsed between the IFN-a therapy and chemotherapy in our patients, a possible delayed synergistic effect cannot be excluded.

Two of our patients developed deep venous thromboses while receiving continuous TAM. Two other patients received TAM for only five days in each three-week period and had objective responses without developing DVTs. Though these numbers are too small to draw conclusions, it does seem that using TAM for short periods may not diminish its therapeutic effect but may reduce the risk of thrombosis.

In view of these preliminary but encouraging results, we believe that further studies are indicated to see if intermittent TAM in the BCDT regimen reduces the risk of thrombosis without altering its efficacy. Studies combining IFN-a with BCDT to further increase the response rate in this, heretofore, very resistant malignancy also seem appropriate.

Acknowledgements

The authors wish to thank the following faculty members from the Department of Medicine at the West Virginia University School of Medicine and the Mary Babb Randolph Cancer Center for permission to use their patients in this report: Miklos L. Auber, M.D., assistant professor; Russell F. DeVore III, M.D., assistant professor; Paolo Romero, M.D., assistant professor; and Peter C. Raich, M.D., professor.

References

1. Mastrangelo MJ, Bellet RE, Kane MJ, Berd D. Chemotherapy of melanoma. In: Perry MC, editors. Chemotherapy source book. Baltimore: Williams and Wilkins, 1991:886-907.
2. Del Prete SA, Maurer H, O'Donnell J, et al. Combination chemotherapy with cisplatin, carmustine, dacarbazine and tamoxifen in metastatic melanoma. Cancer Treat Rep 1984; 68:1403-5.
3. McClay EF, Mastrangelo MJ, Berd D, et al. Effective combination chemo/hormonal therapy for malignant melanoma: experience with three consecutive trials. Int J Cancer 1992;50:553-6.
4. Karakousis CP, Lopez RE, Bhakoo HS, et al. Estrogen and progesterone receptors and tamoxifen in malignant melanoma. Cancer Treat Rep 1980;64:819-27.
5. Meyskens FL, Voakes JB. Tamoxifen in metastatic malignant melanoma. Cancer Treat Rep 1980;64:171-3.
6. Rose C, Pedersen L, Mouridsen HT. Endocrine treatment with anti-estrogen, anti-androgen or progestagen of advanced malignant melanoma: three consecutive phase II trials. Eur J Cancer Clin Oncol 1985;21:1171-4.
7. Zava DT, Goldhirsch A. Estrogen receptor in malignant melanoma: fact or artefact? Eur J Cancer Clin Oncol 1983;19:1151-9.
8. Gill PG, De Young NJ, Thompson A, et al. The effect of tamoxifen on the growth of human malignant melanoma *in vitro*. Eur J Cancer Clin Oncol 1984;20:807-15.
9. McClay EF, Albright K, Jones J, et al. Modulation of cisplatin (DDP) sensitivity by tamoxifen (TAM) in human malignant melanoma. Proc Am Soc Clin Oncol 1991; 10:291.
10. Cocconi G, Bella M, Calabresi F, et al. DTIC vs. DTIC plus tamoxifen in metastatic malignant melanoma. Proc Am Soc Clin Oncol 1990;9:278.
11. Buzaid AC, Murren JR, Durinage HJ. High dose cisplatin with dacarbazine and tamoxifen in the treatment of metastatic melanoma. Cancer 1991;68:1238-41.

New Manuscript Guidelines

All scientific manuscripts should be submitted on disc in the following languages: Wordperfect 4.2, 5.0, and 5.1; Word; Word for Windows; and WordStar. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

No more than 25 references will be published free of charge and they must be presented in the style based on the formats used by the U.S. National Library of Medicine in *"Index Medicus."*

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Medical Grand Rounds

West Virginia University Health Sciences Center

Edited by Irma H. Ullrich, M.D., Professor of Medicine, Section of Endocrinology and Metabolism

Cystic fibrosis: Current concepts

DISCUSSANT:

HENRY L. ABRONS, M.D.

Associate Professor, Section of Pulmonary and Critical Care Medicine and Mountain State Cystic Fibrosis Center, West Virginia University School of Medicine, Morgantown

Abstract

Cystic fibrosis (CF), a common fatal genetic disease, is a multisystem disorder whose pathogenesis has recently been linked to defects in CFTR, a newly discovered protein. CFTR is a molecular channel which controls chloride concentration in secretions of the sweat glands and the respiratory, GI, and reproductive tracts. Defective forms of CFTR, arising from various mutations in its gene, are responsible for the inadequate hydration of mucus, pancreatic juice, and other exocrine secretions. The result is dysfunction of the lungs, pancreas, and other involved organs. This article describes the diagnosis, clinical features, and approach to management of CF.

Introduction

Cystic fibrosis (CF) is the most common fatal genetic disease in the Caucasian population. Approximately 5% of Caucasians are carriers of the defective gene, and one in every 2,500 to 3,500 newborns develops the disease. The pattern of inheritance is autosomal recessive, and heterozygotes are without clinical disease.

Prior to the establishment of a network of special CF centers in the 1960s, CF was almost uniformly fatal in early childhood. During the past three decades, improvements in the treatment of pulmonary infection and malnutrition have extended the median survival of CF victims in the U.S. to 28 years (1). In 1989, the gene for cystic fibrosis was identified (2), stimulating a surge in basic and clinical investigation. The gene product, named the cystic fibrosis transmembrane conductance regulator (CFTR), is a previously unrecognized protein whose structure was inferred from its genetic code (3).

Over the intervening three years, advances in molecular biology have brought the advent of a new era in the diagnosis, management, and prevention of CF. Important new therapies, and perhaps a cure, are expected to evolve over the next few years.

This article describes current approaches to the diagnosis and management of CF, with the aim of promoting the highest quality of care for patients and families with CF in West Virginia.

Diagnosis

The selection of patients for diagnostic evaluation depends on recognition of the varied and occasionally subtle clinical manifestations of CF.

CF is a multisystem disorder with variable organ involvement. The usual pattern, and the major cause of morbidity, is the combination of pulmonary and pancreatic disease. Other organs which are frequently involved include the nose and paranasal sinuses, hepatobiliary system, GI tract, and reproductive system. Symptoms usually begin in early childhood, but in milder cases the onset may be delayed for two or

Table 1. Clinical Manifestations

A. Respiratory

1. Bronchitis, bronchiectasis
2. Progressive obstructive pulmonary impairment
3. Clubbing, hypertrophic pulmonary osteoarthropathy
4. Atelectasis
5. Allergic bronchopulmonary aspergillosis
6. Hemoptysis
7. Pneumothorax
8. Cor pulmonale
9. Pansinusitis, nasal polyps

B. Non-respiratory

1. Pancreatic disease
   a. Exocrine insufficiency
   b. Diabetes
   c. Recurrent pancreatitis without insufficiency
2. Malnutrition
3. Deficiency of fat-soluble vitamins
4. Biliary cirrhosis
5. Cholelithiasis
6. Intestinal obstruction
7. Heat prostration
8. Female hypofertility and complications of pregnancy
9. Congenital bilateral absence of the vas deferens

C. Additional complications unique to infancy and childhood

1. Meconium ileus/plug
2. Prolonged jaundice of infancy
3. Failure to thrive
4. Hypoproteinemic edema
5. Rectal prolapse

three decades. Thus, individuals with CF may present over a wide age range to practitioners in a variety of specialties, including neonatology, pediatrics, family medicine, internal medicine, pulmonary disease, gastroenterology, allergy, otorhinolaryngology, general surgery, urology, obstetrics, and reproductive medicine.

A thorough history, physical examination, and selected laboratory studies will almost always reveal signs and symptoms of chronic pulmonary disease and malabsorption, with or without other manifestations which occur with lesser frequency (Table 1). However, physicians should appreciate the caveat: "The spectrum of clinical features is so varied and symptoms may be so minimal that one cannot exclude the possibility of cystic fibrosis on the basis of a normal growth pattern, absence of pulmonary disease, or normal pancreatic exocrine function. A patient should never be deprived of an evaluation because of 'looking too well to have cystic fibrosis.'" (4)

Sweat chloride

The main diagnostic procedure is the sweat test, in which chloride concentration [Cl] is measured in a small sample of fluid obtained from sweat glands that have been maximally stimulated by the iontophoretic application of pilocarpine. Testing is indicated in patients of any age who have clinical manifestations consistent with CF (Table 1). In addition, this test should be performed routinely in all siblings of patients with CF.

The sweat test is theoretically straightforward, but accurate results depend upon meticulous technique, since minor flaws in the collection or assay of the sample will cause significant errors in [Cl] measurement. Results are unreliable when obtained by any of the "shortcut" screening techniques or in laboratories which seldom perform the test (5). Dependable results are best obtained by an experienced technician at a CF center, and at least 50 microliters of sweat must be collected for accurate analysis. Values ≤ 20 mmol/liter are normal; values ≥ 60 mmol/liter for children, and ≥ 70 mmol/liter for adults, are diagnostic of CF. Intermediate values are considered equivocal.

Positive tests should be repeated for confirmation, and results which are equivocal or not consistent with the clinical impression should also be repeated. In a minute proportion of cases (0.1% to 0.01%), [Cl] is repeatedly normal or equivocal, in which case the patient should be referred for analysis of a DNA sample.

DNA analysis

CF occurs in individuals who are homozygous for mutations in the CFTR gene. The major mutation, designated △F508, is a deletion of three base pairs resulting in the absence of phenylalanine at position 508 in the CFTR peptide; this occurs in 70% of the chromosomes of North American patients. (The frequency of mutation types varies in other populations.)

Analysis of DNA from CF patients has revealed over 200 different mutations of CFTR. Some are rare or unique, and the identification of all existing mutations remains incomplete at the present time. DNA analysis is expensive and should be carried out under the guidance of a consultant. For carrier detection or prenatal diagnosis, patients should be referred to a genetics clinic.

Pathogenesis/clinical manifestations

Intense interest in the functional role of CFTR has recently led to a partial understanding of how defective CFTR causes the wide array of clinical manifestations. CFTR is a chloride channel spanning the apical membrane of the epithelial cells which form the mucosa of the respiratory, gastrointestinal, and reproductive tracts and the ducts of the exocrine pancreas.

To hydrate the secretions of these organs, H_20 shifts from the epithelium to the lumen by osmotic forces generated by Na^+ ions which are actively pumped into the lumen by the epithelial cells. Na^+ must be accompanied by Cl^- to balance the electrical charges. The Cl^- flux is passive, but is regulated by intracellular messenger molecules which signal the chloride channels to open or close.

In CF, the movement of H_20 into the lumen is restricted by the failure of CFTR to open normally. This causes deficient hydration of the various epithelial secretions (mucus in the respiratory, GI, and reproductive tracts; enzymes and bicarbonate in the pancreas; and probably bile in the liver.) In the sweat duct, where the role of the epithelial cell is absorption from (rather than secretion into) the lumen, a similar impermeability to Cl^- causes the elevation of lumenal [Cl].

Lungs

At birth, the lungs are histologically normal, but once airway mucus secretion begins, excessively viscous material becomes inspissated in small airways. Impaired ciliary clearance of secretions and microorganisms renders the lungs susceptible to colonization and chronic infection with Staphylococcus aureus, Hemophilus influenzae, and Pseudomonas aeruginosa.

The predilection of Pseudomonas to colonize the airways in CF is thought to be related to an interaction between the bacterium and the patient's mucus. The physicochemical properties of CF mucus induce bacterial production of alginate, a mucopolysaccharide which further increases the viscosity of the secretions. The highly viscous secretions in turn overwhelm the capacity of airway cilia to clear debris and microorganisms. Alginate also imparts a characteristic mucoid appearance to cultures of Pseudomonas from CF patients.

Although there is no generalized impairment of cellular and humoral immune mechanisms, Pseudomonas colonization of the lower respiratory tract is almost never eradicated, even after intensive antibiotic therapy.

In the early phase of pulmonary disease, cough and sputum become prominent, with Pseudomonas sometimes imparting a green tint to the sputum. The initial clinical picture often resembles recurrent bronchitis or bronchiolitis. Radiographic abnormalities are rarely prominent in patients with early CF. The symptoms tend to wax and wane, perhaps responding to oral antibiotics, but becoming more pronounced as airway inflammation worsens. Wheezing may occur due to airway hyperreactivity or pooled secretions.

Inflammation associated with chronic infection of the lower respiratory tract in CF inevitably leads to bronchiectasis. With progression, airway secretions become increasingly viscous, profuse, and difficult to clear. Digital clubbing is noted in a high

Figure 1. Chest radiograph showing hyperinflation, diffuse chronic infiltrates, bronchial wall thickening, and upper lobe fibrosis in a 26-year-old man with CF.

proportion of patients, and whenever clubbing is associated with chronic bronchitis or bronchiectasis, the possibility of CF should be entertained. Spirometry demonstrates an obstructive pattern which may or may not be partially reversed by the administration of a bronchodilator such as inhaled albuterol. Spirometry also shows an accelerated longitudinal decline in the forced vital capacity (FVC) and the forced expiratory volume in one second (FEV_1).

Chest radiographs eventually demonstrate thickening of airway walls and diffuse ill-defined infiltrates representing patches of mucus plugging and pneumonitis (Figure 1). Mucosal inflammation and mural microabscesses may ulcerate the bronchial wall, producing hemoptysis which is usually self-limited. Massive hemoptysis is less common and occurs from dilated communications between the bronchial arteries and pulmonary veins in bronchiectatic airway segments. Mucus plugging and collapse of the airways during expiration cause air trapping and hyperinflation of the lungs. Lung volume measurements show that in addition to increased residual volume (reflecting air trapping), there is coexisting restriction of the vital capacity and total lung capacity. Exertional dyspnea develops as lung function becomes progressively impaired and the work of breathing increases. In about 10% of patients, allergic bronchopulmonary aspergillosis further complicates the pulmonary process (6). A recent review discusses pathogenesis at greater length (7).

In the average patient, CF takes several decades to progress to the advanced stage, which is reached when there is chronic hypoxemia, pulmonary hypertension, and the development of cor pulmonale. Pulmonary functional correlates of this stage are FVC less than 40% and FEV_1 less than 25% of their respective predicted values. Even at this stage, patients may survive for several years. However, when respiratory insufficiency is present with severe derangements of PO_2 and PCO_2, the expected survival is less than 2 years.

Pancreas

CF can result in both failure of pancreatic exocrine function and diabetes mellitus. Obstructive plugging of small pancreatic ducts by viscous secretions begins in utero, leading to the destruction of acinar cells, presumably by the release of lytic enzymes. The secretion of bicarbonate and digestive enzymes (lipase, proteases, and amylase) is reduced.

When about 95% of the secretory capacity is lost, malabsorption becomes clinically apparent. Fat and protein digestion are deficient; carbohydrate digestion is less impaired. The most prominent symptom is steatorrhea; the stools are loose, frequent (from 3 to 10 or more per day), and unusually malodorous, and an oily residue from undigested fat may be noted. Stool volume and water content are not increased as in diarrhea.

While a diagnosis of pancreatic insufficiency can usually be based on symptoms, measurement of fat in a 72-hour stool collection may be helpful if quantitative assessment is needed. The indications for other tests of pancreatic exocrine function are limited.

Malabsorption in CF is almost always associated with significant malnutrition. Poor weight gain occurs in spite of increased ingestion of nutrients because of the deficit of calories relative to energy requirements, which are above average due to chronic infection and the increased work of breathing.

There appears to be a vicious cycle between malnutrition and lung disease: the former impairs lung defenses against infection and mucus clearance, while flares of pulmonary infection induce anorexia. The consequences of fat malabsorption include depletion of bile salts (which increases the lithogenic potential of bile), and deficiencies of the fat-soluble vitamins (A, D, E, and K) and essential fatty acids.

Fibrosis of the pancreas may ultimately impinge on the islets of Langerhans, reducing insulin secretory capacity. About 30% of patients develop glucose intolerance, and 5% to 10% eventually develop clinical diabetes, particularly later in the course of CF. These individuals may require insulin, but are not prone to ketosis.

Only 10% to 15% of CF patients retain adequate pancreatic function. These patients tend not be homozygous for the $\triangle$F508 mutation, but have other mutations of CFTR; they have milder pulmonary disease and longer survival. Due to the preservation of enzyme secretion, patients with pancreatic sufficiency may experience recurrent pancreatitis, in distinction to the patient with insufficiency whose pancreas is "burned out."

Other manifestations

The distal intestinal obstruction syndrome (DIOS), also called "meconium ileus equivalent," occurs when the distal small bowel becomes partially or totally obstructed with poorly digested and dehydrated mucoproteinaceous material (8). The presenting features are constipation, crampy abdominal pain, palpable bowel loops filled with impacted stool in the right lower quadrant, and copious fecal material on abdominal radiographs.

Prolonged periods of poorly controlled steatorrhea and abnormal intestinal motility predispose to DIOS, which tends to be recurrent in about 25% of patients, especially those who are older. The condition is troublesome because it may be difficult to differentiate from appendicitis and intussusception, which both occur with increased frequency in CF. Although DIOS responds poorly to enemas and laxatives, oral administration of large volumes of isotonic balanced electrolyte solution (Golytely, Colyte) is effective in purging the obstructing fecal material (9).

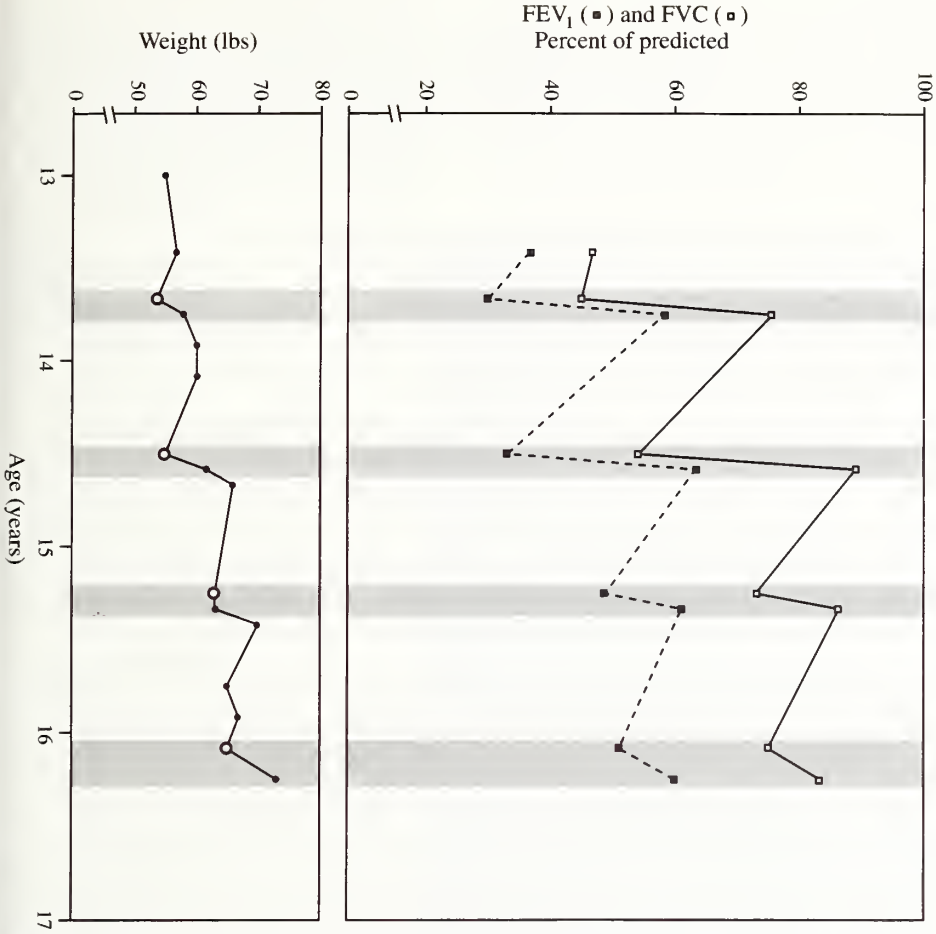


Figure 2. Time course of pulmonary function (FEV_1 and FVC) [upper panel] and weight [lower panel] in a patient with CF. Courses of intensive therapy are indicated by grey bars.

Intrahepatic bile stasis is associated with histologic evidence of focal biliary cirrhosis in about 25% of patients, of whom a few develop portal hypertension, esophageal varices, and end-stage liver disease (10). Liver transplantation may be indicated.

Nasal polyps occur in about 30% of children and adults, contributing to obstruction of the sinus ostia. Symptoms of acute and chronic sinusitis are common. An extensive discussion of other clinical manifestations can be found in a book by L. M. Taussig (11).

Principles of management

Most patients with CF succumb to end-stage lung disease. Although we lack methods to prevent the progression of lung disease altogether, aggressive therapy has been enormously successful in enhancing the quality of life, slowing progression of the disease, and prolonging survival. The successful strategy requires a comprehensive approach in which the patient, family, CF center, and primary care practitioner coordinate measures to maintain adequate nutrition, fight airway obstruction, and suppress pulmonary infection by means of a daily maintenance program that is punctuated by limited courses of more aggressive intervention whenever necessary.

Pancreatic insufficiency is corrected by administering capsules of enteric-coated pancreatic enzymes with each meal. Enzyme doses should be titrated to minimize steatorrhea. The patient should consume a diet of normal composition with sufficient calories to meet daily energy requirements, sustain normal growth, and maintain body weight. Supplements of vitamins A, D, and E, and occasionally vitamin K, are routinely given.

Chest physiotherapy (postural drainage and percussion) is included in the standard daily maintenance program to promote clearance of airway secretions and mucus plugs. Sufficient duration of treatment and correct positioning for each lung lobe are important aspects of effective technique. An aerosolized bronchodilator such as albuterol is generally given before each physiotherapy session. Vigorous physical exercise is encouraged to the extent tolerated.

For chronic pulmonary infection, suppressive anti-Staphylococcal antibiotics are sometimes given continuously according to the results of lower respiratory tract cultures, which should be done at least annually for surveillance, but may need to be done frequently in patients who are ill. Methods for chronic suppression of Pseudomonas are being studied; unfortunately, extended use of oral ciprofloxacin is counterproductive because of the rapid development of bacterial resistance, and should therefore be discouraged.

The accurate identification and sensitivity testing of pathogens in CF sputum requires special laboratory techniques which are available in CF centers. Inevitably, patients will experience exacerbations of pulmonary infection marked by increased chest congestion, fatigue, and weight loss. These exacerbations are usually marked by significant decrements in pulmonary function (Figure 2).

The level of symptoms is not a reliable predictor of deteriorating lung function, which becomes irreversible if left untreated. Therefore, even in the case of stable symptoms, it is important to obtain periodic spirometry. Whenever pulmonary function declines significantly, an aggressive attempt should be made to reverse the process by instituting more frequent chest physiotherapy and high doses of antibiotics specifically targeted to the patient's pulmonary pathogens.

For Pseudomonas, combinations of two drugs should be given. Aminoglycoside pharmacokinetics are altered in CF, and unusually high doses (averaging 10 mg./kg./24 hr. for tobramycin) must be used in most patients to achieve therapeutic blood

Table 2. Selected Current Areas of Investigation

A. Basic science
1. CFTR: function, variants, pharmacologic modulation
2. Transgenic animal models
3. Gene transfer therapy
4. Pseudomonas -- lung interactions

B. Clinical science
1. Aerosolized antibiotics
2. Suppression of lung inflammation by ibuprofen, pentoxyfylline
3. Effect of amiloride on mucus hydration
4. Reduction of mucus viscosity by aerosolized DNase
5. Lung transplantation
6. Genetic diagnosis and screening
7. Early intervention trials

levels. Drug resistance is encountered ocassionally in Pseudomonas aeruginosa, and frequently in organisms such as Pseudomonas cepacia and Xanthomonas maltophilia, which are particularly difficult to treat. The response to therapy should be monitored by serial spirometric testing, and antibiotics continued until the improvement in lung function is maximal (usually 2 to 4 weeks). Figure 2 graphs the response of pulmonary function and weight to courses of intensive therapy in a CF patient. In addition, current and hypothetical approaches to the management of pulmonary infections are discussed in a review by Thomassen and colleagues (12).

Patients with end-stage lung disease may be candidates for lung or heart-lung transplantation. One-year survival in the most experienced centers approaches 80% (13).

Role of the CF center

The care of CF is a rapidly evolving science and some current areas of investigation are listed in Table 2. The most innovative is gene replacement therapy, which is now awaiting clinical trials. The many facets of modern management require the collaboration of physicians in various specialties, but also essential are the contributions of other professionals with special expertise in the application of their respective disciplines to the care of the CF patient. These individuals include nurses, respiratory therapists, social workers, dieticians, and laboratory personnel. In addition, prolonged survival in CF has heightened the need for psychological support to deal with such issues as anxiety, depression, and dying. As CF patients enter adulthood, many achieve satisfying lives. Several have contributed to CF research and care as scientists, physicians, and nurses. Under the leadership of the CF Foundation in Bethesda, Md., a nationwide network of CF centers conducts research and provides diagnostic services, consultation, clinical care, and teaching. Physicians are encouraged to enroll West Virginia patients in the Mountain State CF Center, which currently follows about 100 patients (phone 293-4661 to register adults or 293-4451 to register children.)

References

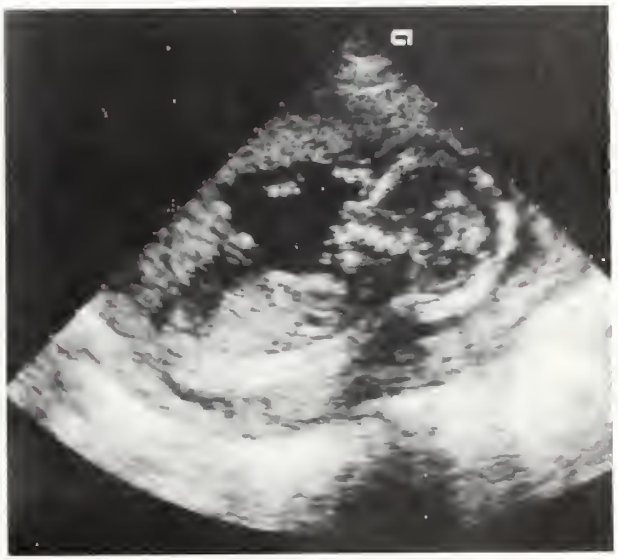
1. FitzSimmons SC. The changing epidemiology of cystic fibrosis. J Pediatr 1993;122:1-9.
2. Rommens JM, Iannuzzi MC, Kerem B, et al. Identification of the cystic fibrosis gene: chromosome walking and jumping. Science 1989;245:1059-65.
3. Riordan JR, Rommens JM, Kerem B, et al. Identification of the cystic fibrosis gene: cloning and characterization of complementary DNA. Science 1989;245:1066-73.
4. Rosenstein BJ, Brusilow SW, Langbaum TS, et al. Cystic fibrosis: problems encountered with sweat testing. JAMA 1978;240:1987-8.
5. Rosenstein BJ, Langbaum TS. Diagnosis. In: Taussig LM, editor. Cystic fibrosis. New York: Thieme-Stratton, 1984:87.
6. Laufer P, Fink JN, Bruns WT, et al. Allergic bronchopulmonary aspergillosis in cystic fibrosis. J Allergy Clin Immunol 1984;73:44-8.
7. Zach MS. Lung disease in cystic fibrosis — an updated concept. Pediatr Pulmonol 1990; 8:188-202.
8. Rubenstein R, Moss R, Lewiston N. Constipation and meconium ileus equivalent in patients with cystic fibrosis. Pediatrics 1986;78:473-9.
9. Cleghorn GJ, Stringer DA, Forstner G, Durie P. Treatment of the distal intestinal obstruction syndrome in cystic fibrosis with a balanced intestinal lavage solution. Lancet 1986;i:8-11.
10. Kopelman H. Cystic fibrosis 6: gastrointestinal and nutritional aspects. Thorax 1991;46:261-7.
11. Taussig LM, editor. Cystic Fibrosis. New York: Thieme-Stratton, 1984.
12. Thomassen MJ, Demko CA, Doershuk CF. Cystic fibrosis: a review of pulmonary infections and interventions. Pediatr Pulmonol 1987;3:334-351.
13. Smyth RL, Higenbottam T, Scott J, Wallwork J. Cystic fibrosis 5: the current state of lung transplantatation for cystic fibrosis. Thorax 1991;46:213-6.

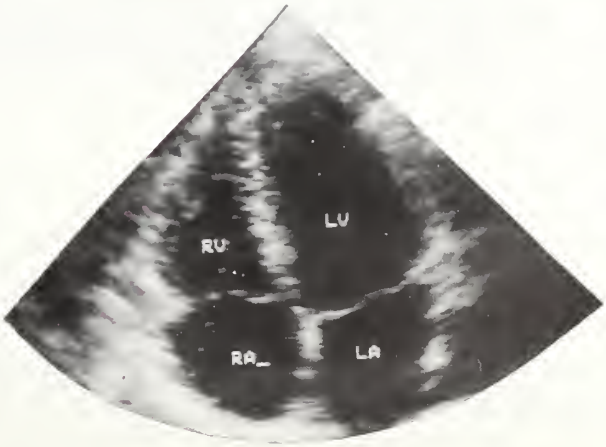
Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time

sound





Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

President's Page

Robert P. Pulliam MD.

Policies!

Policy is defined as "a definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions."

Actions by the current West Virginia Legislature exhibit none of these characteristics of policy! The Legislature froze the promise and policy of planned roll backs in property tax levy rates thus increasing citizens' property taxes by between $11 and $29 million. The Legislature reduced the already awarded investment tax credits thus increasing taxes on businesses. Finally, the Legislature required health care providers to pre-pay taxes on money not yet received and instituted a gross receipts tax on health care providers.

These first two actions represent broken policies; the third displays a new and dangerous policy as government seeks more and unique ways of increasing the tax burdens on already overburdened citizens.

The table at the right represents the votes by the House members on Senate Bill 2 -- the Medicaid provider tax.

Is there any doubt what policy the West Virginia State Medical Association should adopt? If there is doubt regarding the policy, there is no hope!

Robert P. Pulliam, M.D.

West Virginia House of Delegates
1st Extraordinary Session

Senate Bill 2 – Medicaid Provider Tax

Passage PASSED
YEAS: 68
NAYS: 28
NV: 6
EXC: 0

YEAS: 68

Ashcraft	Fantasia	Martin	Rutledge
Beach	Farris	McGraw	Schoonover
Bennett	Flanigan	Mezzatesta	Smith
Brown	Fragale	Michael	Sorah
Browning	Gallagher	Miller, D.	Spencer
Campbell	Harrison	Moore	Staton
Carper	Heck	Nicol	Stewart
Collins	Henderson	Paxton	Tribett
Compton	Hendricks	Pethtel	Varner
Cook, D.	Houvouras	Phillips	Vest
Cook, S.	Huntwork	Pino	White, H.
Dempsey	Johnson	Preece	White, P.
Douglas	Kiss	Prezioso	Whitman
Doyle	Leach	Proudfoot	Willison
Ellis	Linch	Reed	Yeager
Evans	Lindsey	Riggs	Chambers-SPKR
Everson	Manuel	Rowe	Higgins

NAYS: 28

Anderson	Faircloth	Miller, M.	Richards
Ashley	Huffman	Nesbitt	Ryan
Beane	Kessel	Oliverio	Trump
Border	Leggett	Overington	Wallace
Brum	Louisos	Petersen	Walters
Burk	Love	Pettit	White, L.
Facemyer	McKinley	Pulliam	Warner

Circling buzzards

How many recruiters have contacted you in the past month? If there have been fewer than two or three, there is something wrong. You haven't been opening your mail or your receptionist is screening your phone calls.

It used to be that it was just the Air Force, the Navy or the Army which would once or twice a year mail slick material telling of the excitement, the rewards, and the security of a medical career in the military. It has always been somehow reassuring and flattering to know there is someone out there who, even in my aging and wearied condition, really wants me.

The appearance of the headhunters in such numbers over the past year or so was just enough to turn my head until I walked in on a discussion in the doctor's lounge one day. All of the physicians were experiencing the same calls and letters, and it obviously sounded tempting. It was clear that, were doctors not universally afflicted with tendencies similar to those of a groundhog in establishing inviolable routes to follow and patterns of doing things, the area would soon be clear of doctors.

The next headhunter obliged me with an answer to their puzzling interest. "West Virginia is prime territory," he said. "This is a happy hunting ground for recruiters. You guys are stuck in a state crippled with a bad economy, cursed with corrupt politicians and plagued with predatory lawyers. The doctors here really have the worst malpractice situation in the whole country."

That was before provider taxes! Now we seem to stand accused of being ungenerous to the poor and the sick. After listening to public discussions of our medical care system and its faults it would seem we are to be taxed because we have allowed epidemics to sweep through the ranks of the medically needy, allowed victims of disease and accidents to suffer and die in the streets and the gutters, and ignored pregnant women, crippled children and everyone's grandparents. Such tripe. Such cant.

Those very horror stories are now much more likely to occur. West Virginia's beauty will no longer be enough to attract. Its green, its hills, valleys and streams are unlikely to be sufficient to keep its doctors. West Virginians, as reflected in their politicians, are corrupt, mean, surly, grasping, vindictive and mean spirited. Certainly, not people you would want for neighbors.

We have pointed out in these pages on many previous occasions that ordinary, apolitical people very consistently rank medical care number one among their list of priorities. We have pointed out that the worst blunder any administration can make, and the one about which the public will be least forgiving, is to damage what the public now has in medical care.

We fear Governor Caperton, his administration and present members of the Legislature have made such a terrible blunder. They have damaged irretrievably what West Virginia has had in medical care.

Doctors will be leaving West Virginia for better opportunities with friendlier people and less craven politicians who might welcome, appreciate them more, and treat them more fairly.

Medical recruiters might not like the imagery but they are like buzzards circling over our green hills. In this case, they eye a bleeding, mortally-wounded medical care system.

Stephen D. Ward, M.D.

In My Opinion

OMA offers physicians a means of survival

It has been most difficult for the physician's office staff to stay abreast of regulations, both on the state and federal level, regarding HCFA, third-party payors, par & non-par, CPT and ICD-9-CM coding, and then most recently E&M codes, electronic claims submission, UPIN requirements, global surgery, PAAS, ADA, CLIA, and OSHA. Now, it seems we will be contending with PPOs, HMOs, IPAs, capitations, gatekeepers, and risk pools.

One of the ways most physicians have found to survive these rapidly changing regulations and requirements is to have a responsible person in the office who is knowledgeable in all aspects of our ever-changing world. Whether this is an "office manager" or someone who has assumed the responsibility of a supervisory role, most have found the Office Managers Association of Health Care Providers, Inc. (OMA) to be the answer.

This association was organized in 1984 and now exceeds 300 members, with 11 active chapters statewide. The members are dedicated to achieving the OMA's objectives which include providing educational opportunities, monitoring the development and promoting awareness of proposed legislation which impacts health care, and networking with colleagues. With the current issues of health care reform and managed care, it is essential that individuals employed in a managerial capacity stay abreast of the most recent developments.

Physicians should consider taking a second look at this organization and encourage their managers to take advantage of the wealth of information available through their participation. The 7th Annual Conference of the Office Managers Association of Health Care Providers, Inc., will take place November 11-13 at Canaan Valley Resort with the timely theme, *"Health Care Reform: Survival Techniques."* This will be an excellent educational opportunity for the physician and his/her manager.

Clara Marie Clay
Janet Strohl
OMA Conference Committee

Our Readers Speak

Comparison of infant mortality rates meaningless

The letter by Dr. William T. Wallace Jr., commissioner of the West Virginia Bureau of Public Health, regarding Dr. Pulliam's article on obstetrical care in West Virginia, illustrates the folly of trying to compare infant mortality rates between countries.

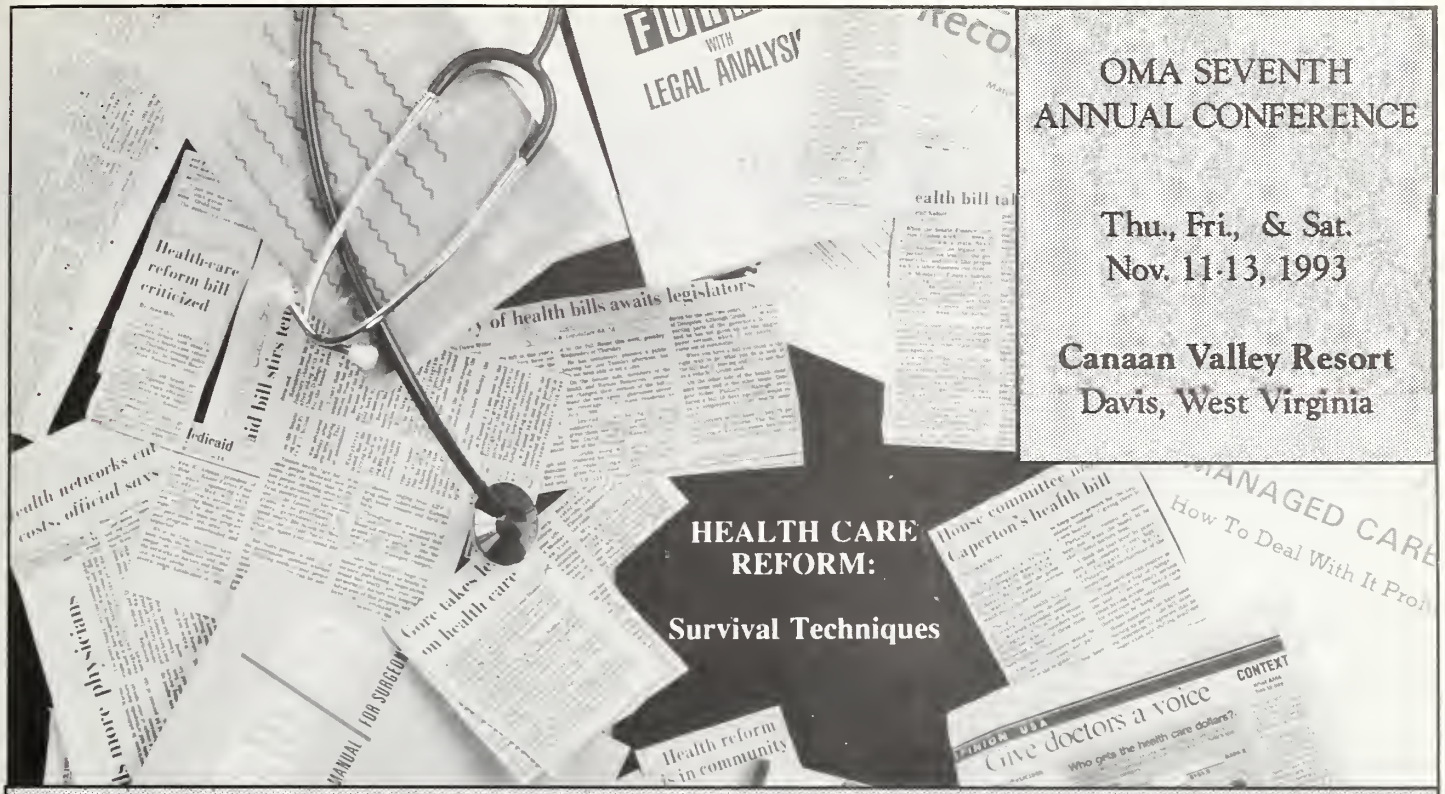
If each state is free to make its own definition of what constitutes a fetal death, then there is no uniformity. The definition, as given by Dr. Wallace, is so broad that a death of a fetus at two months gestation could conceivably be defined as a fetal death since it may have signs of life at that stage.

The opponents of United States' medical care often cite statistics from other countries to show that our medical care is inferior because of our fetal death rate. The country that we are most often compared with is Sweden. In Sweden, reporting of infant mortality is the responsibility of the parents, not of the hospital or of the medical care system. The parents have five years in order to make this report and there is no penalty for non-reporting. In addition, Sweden is able to exclude the figures from Lapplanders, an indigenous group of people who have lived in Sweden for centuries, but who are not considered Swedes. If the United States were able to exclude blacks, we would be number one.

In this country, a fetus weighing 1,000 grams may be put in a neonatal intensive care unit. The mortality rate may well be 50% for this weight group which would translate to 500 deaths per 1,000 births; but in some other countries which report a lower infant mortality rate than ours, this may be regarded as a non-viable fetus and considered as an abortion, rather than a fetal death.

Until there is complete uniformity of definitions, comparisons between states and comparisons between countries are meaningless.

Wallace D. Johnson, M.D.
Beckley



MARK YOUR CALENDAR

Charleston Area Medical Center
Presents

Advanced Trauma Life Support Course (ATLS)

Saturday-Sunday, August 14-15, 1993

Program Director:
James W. Kessel, M.D.
Medical Director - Trauma Services
Charleston Area Medical Center

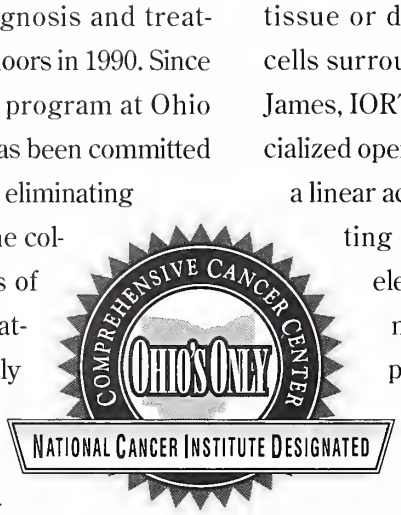
Location:
Charleston Area Medical Center
Education & Training Center
Charleston, West Virginia

For More Information:

For additional information, please contact the CAMC - Continuing Education and Conference Services Department - 348-9581.

At The James, It's A Fine Line

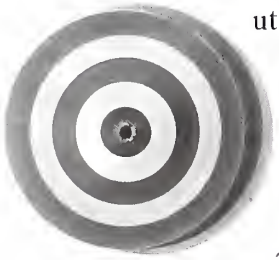
The Arthur G. James Cancer Hospital and Research Institute, a leading center for oncology research, diagnosis and treatment, opened its doors in 1990. Since 1977, the cancer program at Ohio State University has been committed to finding ways of eliminating cancer through the collaborative efforts of research and treatment of a nationally designated Comprehensive Cancer Center. The well-integrated relationship between many disciplines has created an approach that dramatically reduces the lag time between laboratory breakthroughs and practical application.



At present, experts at The James are investigating and administering visionary cancer therapies such as intraoperative radiation therapy (IORT), brachytherapy, taxol, 13-cis retinoic acid and numerous other therapies on patients from over 23 states and 2 foreign countries.

Intraoperative Radiation Therapy

IORT, performed during surgery, utilizes targeted radiation to reduce or eliminate tumors without penetrating overlying tissue or damaging noncancerous cells surrounding the tumor. At The James, IORT is administered in a specialized operating suite equipped with a linear accelerator capable of emitting six million to 18 million electron volts. During treatment, a circular cone is positioned on the tumor and laser beams are used to align the accelerator before the prescribed high dose of radiation is applied. A minimum of 70 patients annually will be treated in the IORT suite.

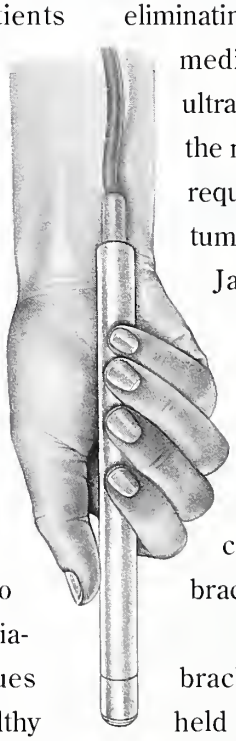


Brachytherapy

Brachytherapy, or radiation implantation, destroys cancer cells by delivering radiation directly to a tumor. Radiation oncologists place radioactive material inside or in close proximity to the tumor so that a very high dose of radiation can be delivered to the tumor with little of the radiation going to the healthy tissues around the tumor. Because healthy tissue remains undamaged, side effects are usually minimal.

The James, one of the leading proponents of brachytherapy, activ applies several forms of brachyther for various cancers and is one of few centers to implant young child

Early methods of brachyther often required surgery and leng hospitalization and exposed patie families and nursing staff to radiat Researchers at The James are sp heading efforts on several front overcome these problems. High d rate brachytherapy allows the tr ments to be given in a few minu on an outpatient basis while tot eliminating radiation exposure to medical staff. Fluoroscopy a ultrasound can be used to gu the needles into tumors with requiring surgery to expose tumor. The researchers at James have combined advantages of IORT a brachytherapy to deli intraoperative high d rate remote brachythe py to tumors normally in cessible to either IORT brachytherapy.

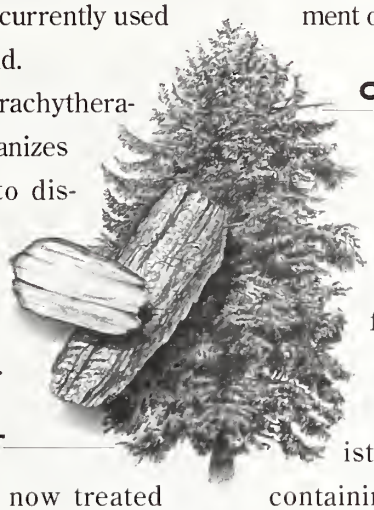


Radioimmunoguid brachytherapy utilizes a ha held instrument that can det the radioactive material remaining small tumors yet not visible to the geon. A critical innovation in can

EEN RESEARCH AND TREATMENT.

atment, the instrument was developed at OSU and is currently used oughout the world.

The Section of Brachytherapy at The James organizes nual symposia to disminate the latest information this emerging ology treatment.



TAXOL

The James has now treated ients from eleven states with taxol der a special National Cancer Institute Compassionate Use Program for ients with advanced ovarian cancer. all, more than 54 patients have been ated at The James, the site of Ohio's y NCI-designated Comprehensive ncer Center. This experimental atment uses the scarce anti-cancer g taxol, currently derived from the k of the Pacific Yew tree. The taxol gram at The James is designed y for women who have previously ed other treatment regimens and o have progressive disease. Other otocols using taxol in first line treatent are also available.

The Comprehensive Cancer Center currently one of three centers in the ited States using taxol in the treatent of breast cancer, and one of only two centers using taxol in the treatment of head and neck cancer.

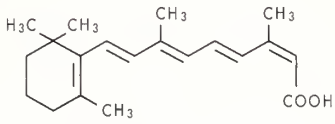
BORON NEUTRON CAPTURE THERAPY

Boron neutron capture therapy, which might offer significant promise for treating brain tumors, was first proposed by Dr. William Sweet in the 1950's.

Following the administration of delivery agents containing boron-10, the tumor is then irradiated with neutrons, resulting in a nuclear fission reaction yielding high energy radiation (alpha particles in Lithium-7 nuclei). A team of researchers at the Comprehensive Cancer Center is attempting to develop different boron delivery systems that will deliver amounts of boron to the tumor large enough to be effective. Researchers are also working in other aspects of BNCT, including the development of models to test therapeutic efficacy, alternative neutron sources and clinical treatment planning.

13-CIS RETINOIC ACID

A seven-year study of 13-cis retinoic acid currently is underway to test the effectiveness of prolonged low-dose 13-cis retinoic acid in reducing the risk of second primary tumors in patients who have had head and neck cancer which has been controlled by surgery and/or radiotherapy. In addition, researchers are evaluating the kind and number of toxicities of low-dose 13-cis retinoic acid administered daily for three years.



{ 13-*cis* Retinoic Acid }

THE OHIO STATE UNIVERSITY

PROGRESS AND POSSIBILITIES

Every day, tremendous strides are being made on many cancer fronts. Yet, it's a long way until total eradication of this ancient malady is achieved. However, the symbiotic relationship between research and treatment at The Arthur G. James Cancer Hospital and Research Institute forms a powerful wedge that is continually forcing the door open a little wider in the search for a cure.

THE ARTHUR G. JAMES CANCER HOSPITAL AND RESEARCH INSTITUTE

0 West Tenth Ave., Columbus, OH 43210, 1-800-638-6996

©1993

At Annual Meeting

AAP leader to deliver Flink Address; Emory professor to present Thomas L. Harris lecture

George D. Comerci, M.D., F.A.A.P., vice-president elect of the American Academy of Pediatrics, who is the uncle of WVSMA President-Elect James L. Comerci, M.D., will present this year's Edmund B. Flink Address at the WVSMA's 126th Annual Meeting at The Greenbrier. Following the Flink Address, John G. Hunter, M.D., an associate professor in the Department of Surgery at Emory University, will deliver the Thomas L. Harris Address.

Both of these presentations will be given during the First Session of the WVSMA House of Delegates on Friday, August 20. Dr. Comerci's speech is entitled *"Health Care Reform: Revolution, Civil War, or Business as Usual?"* Dr. Hunter's lecture will focus on *"Minimally Invasive High Tech Surgery: When Is Progress Really an Advance?"*

Comerci

Hunter

Dr. Comerci received a pharmacy degree from Rutgers University and obtained his medical degree from Temple University Medical School in 1959. He interned with the Public Health Service and completed his residency at Saint Christopher's in Philadelphia.

Following his residency, Dr. Comerci went into private practice in New Jersey for four years and then left the state when he was appointed director of the Outpatient Department at Glennon Hospital at the St. Louis University Medical School. In 1969, he relocated to Tucson, Ariz., to become the director of ambulatory pediatrics and deputy head of the Department of Pediatrics at the University of Arizona. Dr. Comerci spent more than 20 years as a full-time faculty member at the university, serving also as the first associate dean for continuing medical education and as a professor of pediatrics.

In 1991, Dr. Comerci assumed his present posts as director of pediatric and adolescent medicine at the Desert Hills Center for Youth and Families in Tucson. During his years in the Tucson medical community, Dr. Comerci has also served as medical director of the Adolescent Medicine Inpatient Unit at Tucson Medical Center; as medical director for Tucson's Center for Youth Development and Achievement; and as medical director for the Tucson Job Corps.

Recently elected vice-president elect of the American Academy of Pediatrics, Dr. Comerci is a former president of the Ambulatory Pediatric Society, the Arizona Pediatric Society and the Pima County Pediatric Society. He is board certified by the American Board of Pediatrics and a fellow of the Society for Adolescent Medicine. In addition to delivering the Flink Address, Dr. Comerci will be one of the featured speakers for the Scientific Session at the WVSMA Annual Meeting entitled *"Doctors View Today's Dysfunctional American Family."*

Dr. Hunter is a native of New Hampshire who received a B.A. degree from Harvard University and his medical degree from the University of Pennsylvania in 1981. He completed his surgical internship and his residency in general surgery at the University of Utah, where he also was a research fellow in lasers and endoscopic surgery.

Following his residency, Dr. Hunter completed fellowships in surgery at Massachusetts General Hospital and at the University of Western Ontario in Canada. From 1988-1992, he worked as the medical director of the Laser and Endoscopic Surgery Unit at the University of Utah Medical Center and the Salt Lake Veterans Administration Medical Center. In addition, during this time Dr. Hunter was also an assistant professor of surgery at the University of Utah.

Last year, Dr. Hunter relocated to Atlanta to accept his current positions as director of the Emory Endosurgical Center at the Emory University School of Medicine and as an associate professor of surgery. An avid researcher, Dr. Hunter currently is working on two research grants, *"The Medical Applications of the Mark III Free Electron Laser,"* and *"Prospective Randomized Trial of Laparoscopic vs. Open Appendectomy."*

A fellow of the American College of Surgeons, Dr. Hunter is a board member of the Society of American Gastrointestinal Endoscopic Surgeons and is a member of the American Society for Gastrointestinal Endoscopy, the American Society for Lasers in Medicine and Surgery, the Association for Academic Surgeons, and the Society for Surgery of the Alimentary Tract. A consulting editor for the *American Journal of Surgery* and the *Archives of Surgery,* Dr. Hunter has written three books and over 60 articles, book chapters and abstracts.

WVSMA Annual Meeting Preliminary Program

Tuesday, August 17, 1993

6 p.m.	Executive Committee Meeting and Dinner

Wednesday, August 18, 1993

8 a.m.	Executive Committee Meeting *(continued)*
11:30 a.m.	Council Luncheon
11:30 a.m.	Component and Specialty Society Presidents Luncheon
1:30 p.m. - 4:30 p.m.	WVSMA Council Meeting
Noon - 4:30 p.m.	Registration/Exhibit Visitation
6:30 p.m. - 7:30 p.m.	Presidential Reception

Thursday, August 19, 1993

8 a.m. - 2 p.m.	Registration/Exhibit Visitation
8 a.m. - noon	Scientific Session *"Doctors View Today's Dysfunctional American Family"* Glen Aukerman, MD - Morgantown George Comerci, MD - Tucson, Ariz. Michael A. Kelly, MD - Daniels David Z. Morgan, MD - Morgantown Michael Thase, MD - Pittsburgh, Pa.
Noon - 1:30 p.m.	Lunch & Learn *(featuring Ronald Alexander, JD, Cleveland, Ohio, and Visiting Dignitaries)*
1:30 p.m.	Resolutions Committee Meeting *(open)*
2 p.m.	Tournaments
4 p.m.	1994 Annual Program Committee Meeting
6:30 p.m. - 7:30 p.m.	Reception *(sponsored by CNA/McDonough Caperton Insurance Group)*
9 p.m. - 11 p.m.	Dance Lessons *(featuring Sherry & Jerry Rose)*

Friday, August 20, 1993

7:30 a.m. - 8:30 a.m.	WVSMA Surgery Section Breakfast
8 a.m. - 4 p.m.	Registration/Exhibit Visitation
8 a.m. - 12:30 p.m.	WVSMA Dermatology Society Meeting
8:30 a.m.	First Session/House of Delegates E. B. Flink Address *(presented by George Comerci, MD, Tuscon, Ariz.)* T. L. Harris Address *(presented by John G. Hunter, MD, Atlanta, Ga.)*
Noon	WESPAC Lunch and Learn *(featuring Visiting Dignitaries)*
Noon	WV Academy of Otolaryngology Meeting
Noon	WVSMA Cancer Committee Meeting
Noon	WV Chapter of American Academy of Pediatrics Meeting
Noon	WV Psychiatric Association Meeting
12:30 p.m.	WVSMA Publication Committee Meeting
1 p.m.	WV Orthopedic Society Meeting
3 p.m.	Resolutions Committee Meeting
6 p.m. - 7 p.m.	Reception *(sponsored by WVU/MCV Alumni Associations)*
8 p.m. - Midnight	Dance and Entertainment

Saturday, August 21, 1993

7 a.m. - 8 a.m.	Ohio County Medical Society Meeting
7:30 a.m. - 8:30 a.m.	Kanawha Medical Society Meeting
7:30 a.m. - 9 a.m.	Young Physicians Section Meeting
7:30 a.m. - 9:30 a.m.	WV Radiological Society Meeting
8 a.m. - 12:30 p.m.	WVSMA Dermatology Society Meeting
8:45 a.m.	Second Session/House of Delegates AMA President's Address *(presented by Joseph Painter, MD)*
Noon - 1 p.m.	Luncheon Honoring Past Presidents, Visiting State Presidents and 50-Year Graduates
Noon - 1 p.m.	WVSMA Sports Medicine Section Meeting
1:30 p.m.	Second Session/House of Delegates *(continued)*
6 p.m. - 7:30 p.m.	Reception Honoring 1993-94 WVSMA and WVSMAA Officers

Special Honor

Dr. James Boland, a professor of surgery at the Charleston Division of the WVU School of Medicine, is congratulated by Dr. Michael Lewis, associate vice president for health sciences at WVU, as he presents him with this year's William J. Maier Education Award. This annual award is given to an individual who has made an outstanding contribution to the field of health education during the preceding year.

Cape Cod site for 21 mental health courses

The Cape Cod Institute is a summer-long series of postgraduate courses for professionals in mental health, health science, and applied behavioral science. This program is sponsored by the Department of Psychiatry at the Albert Einstein College of Medicine and will include sessions on psychodynamic therapy, behavioral medicine, brief therapy, humanistic psychology, psychological assessment, neuropsychology, family therapy, childhood and adolescence, and organizational development.

Courses will be held weekday mornings from June 28-September 3, from 9 a.m. - 12:15 p.m., leaving the afternoons free for leisure and study. Optional discussion groups and social gatherings are arranged and a student rate is available.

A complete course catalogue for the Cape Cod Institute may be obtained by phoning the Einstein College of Medicine at (718) 430-2307.

WVU clinical ophthalmology conference set

The West Virginia University Department of Ophthalmology will present its 14th Annual Clinical Ophthalmology Conference from October 15-16 at the Lakeview Resort and Conference Center in Morgantown.

This year's program will feature Manus Kraff, M.D., lecturing on *"Anterior Segment Surgery"* and Steven Dresner, M.D., speaking on the topic of *"Ophthalmic Plastic and Reconstructive Surgery."*

In conjunction with this annual seminar, three other meetings are planned: a course for ophthalmic technicians entitled *"The ABC's of Pediatric Assessment;"* a workshop for ophthalmic billing personnel on *"Medicare Claims Management '93: Technology and Requirements;"* and a seminar on the subject of *"Effective Patient Relations"* which is designed for ophthalmic personnel. JCAHPO and/or CEU credit are pending for these three sessions.

For more details, phone Patricia Schumann in the Department of Ophthalmology at (304) 293-3757.

ICS-US issues call for abstracts for 1994 annual meeting

The International College of Surgeons, U.S. Section has issued a call for abstracts for next year's annual meeting which will be held at the Stouffer Hotel in Cleveland, Ohio from June 8-12, 1994.

The College is requesting abstracts from all specialty fields for this 56th annual meeting which is entitled *"Invasive Surgery: Is It Obsolete?"* The deadline is September 14.

A submission form can be obtained by contacting the ICS-US Section Office at 1516 N. Lake Shore Drive, Chicago, IL 60610, or faxing the office at (312) 787-9289.

Transplantation subject of seminar

"Broaching the Biological Barriers to Transplantation" will be the topic of the Fourth Annual Rush Symposium on Transplantation, which will be held at Rush-Presbyterian-St. Lukes' Medical Center in Chicago on June 26.

To register or obtain more information, call (312) 942-6242.

AABB teleconference planned for July

The American Association of Blood Banks (AABB) will be holding an audio teleconference entitled *"Ask the Experts"* on July 21 from 2 p.m. - 3:30 p.m. Eastern Standard Time.

This program offers participants an opportunity to ask questions and share in the knowledge offered by experts in a variety of fields within the blood banking community.

For more details about this program, please contact the AABB Education Department at (301) 215-6482.

NIH issues two new consensus reports

National Institutes of Health (NIH) consensus development statements on *"Impotence"* and on *"Early Identification of Hearing Impairment in Infants and Young Children"* were recently released from the NIH Office of Medical Applications of Research (OMAR).

For free, single copies of these consensus statements, phone William Hall at (301) 496-1143.

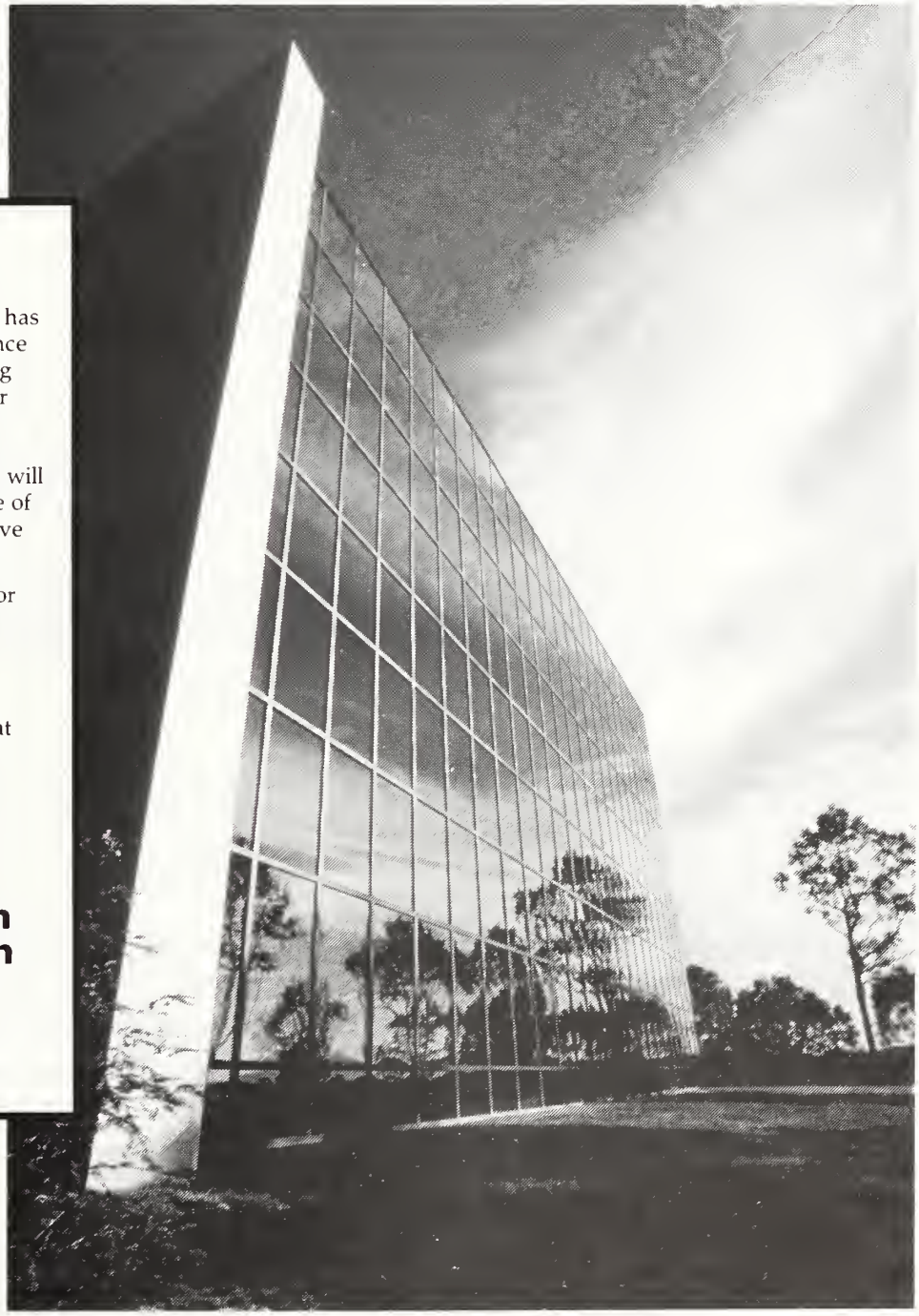
Service is the cornerstone of our business.

Upon a foundation of experience and professionalism, McDonough Caperton has built a regional insurance brokerage firm assisting clients nationwide. Our mission is to provide a distinctive service of outstanding value that will remain the cornerstone of our business as we move forward.

- Comprehensive Major Medical
- Professional Office Overhead
- Term Life
- Medicare Supplement
- Disability Income
- Hospital Indemnity

Call Us. 1-800-344-5139
Extension 708

McDonough Caperton Insurance Group



Corporate Headquarters One Hillcrest Drive, East, P.O. Box 1551, Charleston, WV 25326-1551, Telephone: (304) 346-0611 Fax: (304) 347-0697
With Offices Located in: Florida, Georgia, Kentucky, Ohio, Pennsylvania, Virginia, West Virginia and Bermuda

The West Virginia State Medical Association's

1993 Annual Meeting

August 18-21, 1993

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up Now!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

For more details about other area hotels/motels, contact the WVSMA at 304-925-0342. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1993 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code _____

Specialty _____

Payment by: Check Visa MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	____
	non-member	$175	____
Additional:			
Thursday, Aug. 19 Lunch and Learn (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
Friday, Aug. 20 WESPAC Luncheon (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
		TOTAL:	____

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

WESPAC

Lunch & Learn

Visiting state presidents from Pennsylvania, Maryland, Ohio, Indiana and Virginia, as well as Dr. Joseph Painter, president of the AMA, will be participating in a question and answer session on how POLITICAL ACTION COMMITTEES affect the legislative process.

What is a PAC's role in the legislative process?
How do other state PACs select their candidates to endorse?
What is the PAC's role within the medical society?
What is the future of PACs on a national and state level?

August 20, 1993 at Noon
During the WVSMA Annual Meeting
at The Greenbrier

The WVSMA has applied for CME credits. The cost for the luncheon is $25 and all physicians and auxilians are invited. If you would like to attend, send in the registration form and your check made payable to the WVSMA, P.O. Box 4106, Charleston, WV 25364.

IF YOU'RE INTERESTED IN POLITICS AND ARE CONCERNED WITH THE FUTURE OF HEALTH CARE - -
DON'T MISS THIS MEETING!

WESPAC Lunch & Learn

Name _____

Address _____

Phone _____

_____ Physician _____ Auxilian _____ No. Attending

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

Aug. 7 - First Generation Loss Control Seminar, Clarksburg

Aug. 18-21 - WVSMA's 126th Annual Meeting, White Sulphur Springs

WVU Health Sciences Center - Morgantown

Aug. 29-Sept. 2 - "Oxygen Radicals and Lung Injury," (sponsored by WVU Dept. of Pathology and NIOSH), Lakeview Resort and Conference Center, Morgantown

Raleigh County Medical Society - Beckley

June 22 - "Clinical Experience with Lipid Lowering Agents on the Regression of Coronary Artery Disease," Charles Rackley, M.D., 6:30 p.m., Black Knight Country Club

June 24 - "Atrial Arrhythmias," Thomas von Dohlen, M.D., 6:30 p.m., Black Knight Country Club

Outreach Programs

Key to Sponsors

★ *WVU Health Sciences Center, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Fairmont ★ Fairmont Clinic, July 21, 1 p.m., "Tobacco Cessation," Penny Glover, M.D.

Fairmont General Hospital, July 6, 7:30 p.m., "Malignant Melanoma," *STBA

Logan ☐ Logan General Hospital, noon, "Treatment of Lung Carcinoma in the 1990s," Abdallah Alameddine, M.D.

Man ☐ Man Appalachian Regional Hospital, July 20, 7 p.m., "New Directions in Asthma," Chandra Kumar, M.D.

Montgomery ☐ Montgomery General Hospital, July 7, 12:15 p.m., "Current Treatment of Renal Cell Carcinoma: Roles of Conservative Surgery," Bashir Sankari, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, July 22, noon, "Breast Cancer," Arvind Kamthan, M.D.

Ripley ☐ Jackson General Hospital, July 9, 12:15 p.m., "Reconstruction of Oral Cavity with Implants," David Yates, D.M.D.

New Martinsville ★ Wetzel County Hospital, July 8, 11:30 a.m., "Physiology of Menopause," Douglas Glover, M.D.

Princeton ☐ Princeton Community Hospital, July 19, noon, "Oncology Emergencies," Steven Jubelirer, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, June 28, 4 p.m., "Cancer in West Virginia," R. John Pearson, M.D.

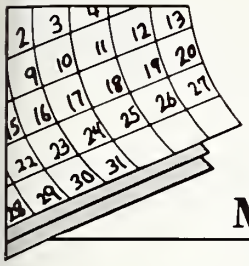
**Speaker to be announced*

HELP PREVENT HEART ATTACK WITH A STROKE.

Any type of aerobic exercise program can help reduce your risk of heart attack and stroke. The only hard part is diving in. To learn more, contact your nearest American Heart Association.

You can help prevent heart disease and stroke. We can tell you how.

American Heart Association



Medical Meetings

June

25-27–Eleventh Summer Symposium in Internal Medicine (sponsored by Eastern Virginia Medical School), Williamsburg, Va.
26–Fourth Annual Rush Symposium on Transplantation (sponsored by Rush-Presbyterian-St. Lukes Medical Center), Chicago
27-29–American Society of Contemporary Medicine and Surgery, Chicago
27-30–American Society of Contemporary Ophthalmology, Chicago

July

6-10–Sixteenth Annual Flap Dissection Workshop (sponsored by Eastern Virginia Medical School), Virginia Beach, Va.
9-11–American College of Allergy & Immunology, Denver, Colo.
15-17–National Health Reform: Making Health a Community Affair (sponsored by the American Health Planning Association), Washington, D.C.
21-25–15th National Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum (sponsored by The George Washington University Medical Center), Houston
25-30–Physicians and their Families Workshop: Balancing Commitments to Family and Profession (sponsored by The Menninger Clinic), Crested Butte, Colo.
27-Aug. 1–55th Annual Meeting of the International College of Surgeons - United States Section, Seattle

August

8-11–Midwest Surgical Association, Lincolnshire, Ill.
11-15–Advanced Seminars in Dermatology (sponsored by the University of California Dept. of Dermatology), Newport Beach, Calif.
18-21–WVSMA's 126th Annual Meeting, White Sulphur Springs
21-25–American Association of Tissue Banks, Boston

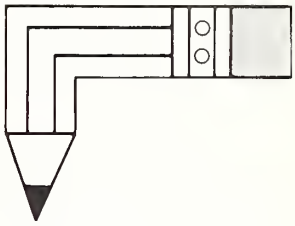
September

7-12–American Academy of Neurological and Orthopaedic Surgeons, Las Vegas, Nev.
9-11–American Gynecological and Obstetrical Society, LaCosta and Carlsbad, Calif.
11-14–The Decade of the Brian: An International Conference (sponsored by The George Washington University Medical Center), Washington, D.C.

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



At the Cardiac Unit

The Icy Madonna
births no hope
as she stares
over the frozen courtyard.

I clench cold fingers until
my palms
wear imprints
of bloody half-moons.

I pray
to the stone statue,
command the motionless
man to live.

She answers.
A green line I know
Is not there slashes
Her face.

I hear
the door close
and do not need
to listen.

Wilma Stanley Acree
Vienna, WV

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

"MY WIFE DOESN'T UNDERSTAND ME... MY NURSE DOESN'T UNDERSTAND ME... AND MY COMPUTER THINKS I'M A MORON."

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

PRAMS data to be analyzed by WVU

The Office of Maternal and Child Health (OMCH) has recently contracted with Drs. C. L. Martinec Ponte and V. J. Norton of West Virginia University for analysis of Pregnancy Risk Assessment Monitoring System (PRAMS) Phase I data.

The PRAMS project is funded by the Centers for Disease Control and Prevention and is designed to survey West Virginia mothers to assess behavioral risk factors and use of health care services. Any woman in West Virginia who has delivered a live infant in the past two to four months is eligible to be selected for participation in this survey. While some data about risk behaviors is available from birth certificates, the PRAMS survey instrument collects more detailed information about these behaviors.

The analysis of Phase I data will be used to provide a historical perspective on the experiences of West Virginia mothers from September 1988 to July 1990. Survey results will be reviewed for correlations between favorable or unfavorable pregnancy outcomes for the mother and her infant in relation to maternal risk factors and/or problems in obtaining or accessing prenatal care services. Results from Phase II analysis (August 1990 to present) will be used to assist OMCH program personnel and health care providers in providing services to reduce behaviors associated with adverse pregnancy outcomes and to improve the delivery of health care services in West Virginia.

For more details on PRAMS or for a copy of the report, contact Tera Thomas at (304) 558-7996 or 1-800-642-8522.

AIDS teleconference set for July 22

The West Virginia AIDS Program will be conducting a teleconference focusing on the clinical aspects of AIDS and AIDS/HIV surveillance. The teleconference will be held July 22 from 7:30 a.m to 9:30 a.m. and will be downlinked to several hospitals in West Virginia.

Dr. Bernard Branson from the Centers for Disease Control and Prevention will provide the keynote address, which will be an AIDS clinical update.

For more teleconference details, call the West Virginia AIDS Program at (304) 558-2950 or 1-800-642-8244.

Training begins for school health program

Cabell, Doddridge, Lincoln, Monroe and Tucker Counties were recently selected to participate in training for the Comprehensive School Health Program, a collaborative effort between the West Virginia Department of Health and Human Resources and Department of Education.

Training will be held this summer for personnel from these five selected counties, as well as for educators from Clay, Hardy, Harrison, Ritchie and Webster Counties, which were selected last year. The West Virginia Health Care Planning Commission has called for comprehensive school health programs in all 55 counties by the 1997-98 school year.

Comprehensive school health involves the integration of community health services into the school system. The eight components include school health education, school health services, school health environment, child nutrition, physical education, counseling, school/community collaboration and staff wellness.

West Virginia is one of several states receiving five-year funding from the Centers for Disease Control and Prevention to develop such programs. West Virginia has also been selected as the National Training and Demonstration Center for the nation.

Non-educators are encouraged to participate in the comprehensive school health effort in an attempt to capitalize on the strengths of different professions. This will ensure that the social, emotional and physical health needs of children are fully met.

For more information about the Comprehensive School Health Program, contact Bob Boggs at (304) 558-0644.

Physicians encouraged to report Lyme disease

State Epidemiologist Loretta Haddy is encouraging physicians to contact the Division of Surveillance and Disease Control with any questions relating to lyme disease reporting. Physicians reported only 13 cases of the disease in 1992, down from the 43 cases reported in 1991. Of the 13 cases, 12 met the Centers for Disease Control and Prevention's Surveillance Cases Definition for a confirmed case.

In addition to providing information about lyme disease reporting, the Division staff can provide case report forms and sample patient education literature.

For more details, call 1-800-423-1271.

Report examines breast, cervical cancer

According to the 1991 West Virginia Breast and Cervical Cancer Incidence and Mortality Report, for every 100,000 women living in West Virginia during 1991, 111 were diagnosed with invasive breast cancer, or 1,036 cases. Of these women, 74% were women age 55 and older. An additional 104 non-invasive, or in situ, cases were also diagnosed, for a total of 1,140 cases.

This report, which was released by the Bureau of Public Health, includes the first available data on the occurrence of breast and cervical cancer among state females, while previous data only included death rates from the diseases. The 1991 invasive cervical cancer rate was 12.3 cases for every 100,000 West Virginia women, or 115 cases. An additional 385 cases were diagnosed in the in situ, non-invasive, stage for a total of 500 cases of cervical cancer. There were 336 deaths due to breast cancer and 42 deaths due to cervical cancer among West Virginia females in 1991.

The West Virginia Breast and Cervical Cancer Incidence Registry was started in 1991 as part of a statewide breast and cervical cancer screening program.

For more information or a copy of the 1991 report, phone Beverly Keener at (304) 558-5358.

The WVSMA & Conomikes Associates, Inc.

Present

MANAGED CARE

How to deal with it properly

- How to avoid HMO/PPO contracting traps
- Capitation vs. Fee-for-Service
- How to get paid what you deserve

Charleston - September 28 Charleston Area Medical Center
3110 MacCorkle Avenue
9 a.m. to 4 p.m. (Lunch provided)

Registration Form

MANAGED CARE: How to deal with it Profitably

Enrollee Name _____

Physician's Name _____

Address _____

City _____

State _____ Zip _____ Phone _____

WVSMA member ($195) ____ Non-member ($225) ____
2 or more ($175) ____ 2 or more ($200) ____

Payment by: Check ___ Visa ___ Mastercard ___

Card Number _____

Expiration Date _____

Signature _____

Registration Fees:

$195 per person (Members/Member's Office staff)
Two or more persons from the same practice $195 for the first enrollee and $175 for each additional enrollee

$225 per person (Nonmembers/Office Staff)
Two or more persons from the same practice $225 for the first enrollee and $200 for each additional enrollee

NOTE: To register more than one person, copy and complete information on a separate sheet.

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the West Virginia University Health Sciences Center, Communications Division, Morgantown

Hillary Clinton presents health care forum at HSC

First lady Hillary Clinton conducted a statewide health care forum entitled "West Virginia Speaks: Our Hopes for Health Care Reform," on Tuesday, May 11, at the Health Sciences Center. The event was hosted by Sen. Jay Rockefeller and WVU.

The forum was designed to allow West Virginians an opportunity to offer ideas to Mrs. Clinton and to Rockefeller as they work to develop a comprehensive health care reform package to deliver to the president. An audience representing a cross-section of state residents was invited by WVU to be present at the event, and Mrs. Clinton and Senator Rockefeller also talked via satellite with state residents from Cabin Creek, New Martinsville, Martinsburg, and Rainelle.

Six television stations from across the state broadcasted the forum live.

Aukerman named family medicine chair

Aukerman

Dr. Glen F. Aukerman, the former president of the American Academy of Family Physicians, has been appointed to chair the Department of Family Medicine.

Dr. Aukerman of Botkins, Ohio, led the 74,000-member organization in 1990 and 1991, and was the deputy director and chief medical officer of the Division of Quality Assurance in the federal Bureau of Health Professions before coming to WVU.

A graduate of the Ohio State University College of Medicine, Dr. Aukerman was in private practice in Jackson Center, Ohio, from 1964 to 1991. For much of that time, he served as a clinical assistant professor at Ohio State, acting as a preceptor for medical students and residents both in his rural clinic and at a Columbus hospital.

Since 1992, Dr. Aukerman has been on the faculty of the University of Tennessee at Memphis as an associate professor of family medicine, serving as scholar-in-residence in the federal Bureau of Health Professions.

D'Alessandri testifies before Congress

D'Alessandri

Dr. Robert M. D'Alessandri, vice president for health sciences and dean of the School of Medicine, was in Washington, D.C., on Monday, May 3, testifying before Congress during the Senate Special Committee on Aging, and the Senate Rural Health Caucus workshop on rural health care.

Dr. D'Alessandri presented the Association of Academic Health Centers' position on a Physician Payment Review Commission's proposal for restructuring graduate medical education. The forum focused attention on revisions to graduate medical education designed to increase the number of primary care physicians practicing in rural areas.

WVUH participates in vascular study

WVUH is one of several U.S. research centers chosen to participate in an international study to determine the best therapy for arterial clots in the legs.

The study, known as TOPAS (Thrombolysis or Peripheral Arterial Surgery), involves the comparison of traditional therapy (vascular surgery to remove the blood clot and rebuild or replace narrow or blocked arteries), and a new type of therapy (administering clot dissolving drugs directly into the clot by way of an intra-arterial tubing or catheter). This is the first comparative study to be conducted to determine whether surgery or thrombolysis is the best first treatment in patients who are at risk for losing a foot or leg.

Dr. Kenneth Granke, director of the WVUH vascular laboratory and assistant professor of vascular surgery; and Anthony Dominic, an instructor of radiology, are leading the study at WVUH.

Pediatric Cardiology Fellowship Program approved by AACGME

Einzig

The WVU Pediatric Cardiology Fellowship Program has been approved by the American Accredition Council for Graduate Medical Education.

This program is directed by Dr. Stan Einzig, professor and section chief of pediatric cardiology.

Newfield named Social Worker of the Year

Neal A. Newfield, Ph.D., director of the WVU Appalachian Family Center and assistant professor in the Department of Behavioral Medicine and Psychiatry, was recently named the 1993 Social Worker of the Year by the West Virginia Chapter of the National Association of Social Workers.

Dr. Newfield has more than 15 years experience teaching, supervising, researching, administering, and delivering marriage and family therapy services in academic settings.

Shumway to lead AAMC southern group

James M. Shumway, Ph.D., associate dean for educational programs in the School of Medicine, has been elected to chair the Southern Group on Educational Affairs of the Association of American Medical Colleges.

Dr. Shumway's two-year term as the representative of 42 medical schools in the southeastern United States will begins in November. As chair, he will help coordinate efforts underway at all the schools to improve the education of future physicians.

Continuing Medical Education Courses

The Department of Radiology, University of Pittsburgh is pleased to announce its **RADIOLOGY** Series of CME courses. This unique series has been specifically designed to provide an excellent update covering the complete spectrum of radiology.

October 15, 1993 AM/PM October 16, 1993 AM	• Abdominal Imaging *Guest faculty: Alec Megibow, M.D. • Pediatric Imaging • Mammography *Guest faculty: Norman Sadowsdy, M.D. ***This has been coupled with the Pitt-Syracuse game, come and enjoy.***	Location: Holiday Inn University Center 100 Lytton Ave. Pittsburgh, PA 15213
February 11, 1994 AM/PM February 12, 1994 AM	• Neuroradiology • Head & Neck Imaging • Nuclear Medicine • Women's Imaging	Location: Sheraton Hotel at Station Square - A Pittsburgh historical landmark
May 13, 1994 AM/PM May 14, 1994 AM	• Interventional Radiology • Chest Imaging • Musculoskeletal Imaging	Location: Sheraton Hotel at Station Square

CME credits will be assigned to each meeting. Tuition is $150.00 per event. Course registration can be arranged through:

For more information:

Name _____

Address _____

_____

City _____ State _____ Zip _____

Mail or fax to:
Clarence J. Mason
Department of Conference Management
Nese-Barkan Building, Fifth Floor
3811 O'Hara Street
Pittsburgh, PA 15213-2593

Fax: (412)647-8222
Tel: (412)647-8261

The second University of Pittsburgh Summer Imaging course is scheduled for June 25-30, 1994 at Historic Colonial Williamsburg. This week long course will provide the practicing radiologist with a thorough review and enable attendees to interact with recognized leaders in the various radiology subspecialties.

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

New project to study temperaments of infants in rural areas

Why does one infant who starts life out crying quite a bit become more easygoing as time passes, while another baby with the same type of temperament stays "difficult"?

Why does one infant who is initially happy and outgoing stay that way, while another baby turns unsociable and insecure?

By looking for answers to these types of questions at the Lincoln Primary Care Center in Hamlin, Margaret Fish, Ph.D., a clinical assistant professor in the Department of Family and Community Health, expects to learn more about parenting in rural families. The study may also shed light on the role strong networks of social support play in child-rearing in rural areas.

According to Dr. Fish, this is the first study on stability and change in infant temperament to have a rural focus. This three-year study is being funded by the Public Health Service's Maternal and Child Health Bureau at a cost of nearly $300,000.

"The individuals in this study have lower incomes and are less educated than the people studied before," Dr. Fish said. "Previous studies were conducted on urban, middle-class subjects and found that it was the caregiver, her view of herself and her world, and the nature of her social environment which helped influence infant temperament. We will see if this same kind of change and stability can be generalized to this group."

The Marshall study may end up showing similar outcomes for both rural and middle-class caregivers, Dr. Fish said. She pointed out that young mothers in rural communities get strong support from relatives, friends and neighbors, a factor which may compensate for educational and economic disadvantages.

Ultimately, the researchers hope to identify mother-infant relationships needing help. A difficult infant born to a young, anxious mother without much social support would benefit from early intervention, Dr. Fish explained. Research suggests that infants with difficult temperaments are apt to have more behavior problems and more difficulty in forming secure relationships later in life.

Dr. Fish's research will also break new ground in the methodology of studying neonatal behavior. A two-year, $73,000 grant from the National Institute of Mental Health will allow Dr. Fish and her associates to add physiological data to their more subjective observations. They will monitor heart rates when the infants experience a variety of stimuli.

Dr. Fish and her assistants plan to study 125 subjects, each of whom they will see five times during regular visits to the Lincoln Primary Care Center. Pregnant women will be interviewed extensively during a routine prenatal visit in their last trimester. Infants will be studied at 2 weeks, 4 months, 9 months, and 15 months of age.

Chairman instituting new biochemistry courses, projects

When Richard M. Niles, Ph.D., left the Boston University School of Medicine last summer to become professor and chairman of the School of Medicine's Department of Biochemistry and Molecular Biology, he had three clear-cut professional goals -- to put his administrative skills to the test, to help the department move ahead, and to create a good research environment for his molecular-level studies of a promising new cancer therapy.

"I think there is a lot of potential here at the medical school which I hope I can have some hand in helping develop," Dr. Niles said recently. "I am pleased that two new graduate courses will be offered this fall. One is an advanced course in the molecular mechanisms that control cell growth and it is in line with the department's increasing emphasis on cell molecular biology. The second new course will focus on molecular endocrinology," he added.

According to Dr. Niles, the biochemistry course for medical students will have a new look as well.

"Students will work in small discussion groups instead of the larger sections they are in now," Dr. Niles explained. "We want to see if we can get students more involved and develop a more effective problem-based learning situation."

In addition to these departmental changes, Dr. Niles is also studying ways to work with high school teachers and students, and is conducting research in cell differentiation and growth. He is working on three grants that bring in about $250,000 a year -- two from the National Institutes of Health and one from the American Institute for Cancer Research.

Dr. Niles' research has implications for difficult-to-beat cancers like lung cancer, which has a higher incidence in West Virginia than nationally. He is investigating how retinoic acid induces tumor cells to regain the differentiated properties that normal cells have. In clinical trials, retinoic acid has kept certain cancers with a high rate of recurrence, such as bladder cancer and head and neck cancer, in remission for long periods of time.

Prior to accepting his post at MU, Dr. Niles was a professor at the Boston University School of Medicine, where he had been on the faculty since 1975. During his career, Dr. Niles has also served as a visiting scientist at the Dana Farber Cancer Institute at the Harvard University School of Medicine, as a research associate in cell biology at the Institute for Cancer Research in Philadelphia, and as a research associate in biochemistry at the University of Massachusetts Medical Center.

Dr. Niles received his B.A. in biology from Rhode Island College, his M.S. in botany from the University of New Hampshire, and his Ph.D. in plant pathology and biochemistry from the University of Massachusetts.

RUN A SPECIAL PRACTICE.

Today's Air Force has special opportunities for qualified physicians and physician specialists. To pursue medical excellence without the overhead of a private practice, talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay each year that are part of a medical career with the Air Force. Discover how special an Air Force practice can be. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

HealthCare Financial Services

A Division of Strategic Health Services, Inc.

1204 Kanawha Boulevard, East
Post Office Box 3882
Charleston, West Virginia 25338

"Your Medical Collection Service"

Affiliated with Charleston Area Medical Center, Inc.

We are proud to be the largest and most sophisticated collection service in West Virginia. Our emphasis is service and client image and our services are marketed exclusively to health care providers. Please call today for a review of our services and what we can do to assist your cash flow position.

J. Bruce Dunlap
Director of Operations

Thomas Harris
Marketing Manager

304-345-4371

In WV 1-800-369-4371 **FAX 304-345-4323**

Obituary

Richard J. Sexton, M.D.

Dr. Richard J. Sexton, 76, of Charleston, died of an apparent heart attack on May 8 while taking a morning walk.

Born in Easton, Pa., Dr. Sexton received a B.S. degree from Muhlenberg College and obtained his medical degree from the Hahnemann Medical College of Philadelphia in 1943. He completed an internship at The Memorial Hospital in Wilmington, Del., and then served in the U.S. Army for two years, attaining the rank of captain.

Following his military service, Dr. Sexton moved to Charleston and established a general practice. In 1948, he became the medical director of the Union Carbide Plant at Institute, where he worked until his retirement in 1982. After retiring, he was a contract relief doctor for the Institute, South Charleston and Tech Center facilities where he worked on a regular basis until the day before he died.

A pioneer in occupational medicine, Dr. Sexton's research on the health effects of ethylene oxide and the coal hydrogenation process was published in medical journals and is still regarded highly in scientific circles. When Union Carbide wanted to make chemicals from coal by the hydrogenation process, he established a first-rate hazard education program. As part of this program, Dr. Sexton conducted quarterly skin checks for employees where skin lesions were measured, photographed, and, if needed, removed and biopsied. He presented his findings at the American Academy of Occupational Medicine meeting in February 1960 and this data was published in the Archives of Environmental Health in May 1960.

Photo Courtesy of *the CARBIDER*

Sexton

In addition, during his career at Union Carbide Dr. Sexton created the first blood bank for employees in industry and won accreditation from the American Association of Blood Banks. He also prepared employee health education programs and pamphlets on a variety of chemicals.

A WVSMA member since 1947, Dr. Sexton was also a member of the AMA and Kanawha Medical Society.

Dr. Sexton donated his body for medical research to the WVU School of Medicine. He is survived by his wife, Norma Veazey Sexton; stepsons, Michael and Stephen; and daughter, Juliana.

Society News

Mercer

WVSMA President Dr. Robert Pulliam was the guest speaker for the society's May meeting.

In addition to Dr. Pulliam's speech, a presentation was given by Kelly Siner of the Lupus Support Group.

Davis & Davis Accounting Services

602 Tennessee Avenue • Charleston, WV 25302
• 304-343-4656 • 800-281-4572 • FAX 304-343-4657

Davis and Davis Accounting provides efficient electronic medical billing to help you receive faster reimbursement. We can bill insurance companies daily, weekly, monthly and/or on demand. As a result of prompt billing, the turnaround time on your reimbursement claims can be reduced by as much as 30 days.

We provide:

- filing of all primary and secondary insurance claims
- patient billing - as lump sum or budget payments
- collections - open line posting, follow up letter on late payments, problem accounts (three letters and turn over for collection)

Billing System equipped with:

- line error checking
- account aging
- cycle billing capablilities
- open line posting
- custom reports tailored to you individual practice

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Articles

How the Health Care Surrogate Act of 1993 will simplify medical care in West Virginia 274

Sexual Misconduct Statement of the West Virginia Board of Medicine[1] 276

Scientific Newsfront

An implication for bone posterity: Dietary calcium intake in medical personnel in southern West Virginia
Alfred K. Pfister, M.D., F.A.C.P. 280

Papillary intraperitoneal neoplasia resembling ovarian carcinoma after removal of benign ovaries
Curtis D. White, M.D. 282

Report of *Pseudomonas aeruginosa* sinusitis in a patient with AIDS
R. Wesley Farr, M.D.
Hassan H. Ramadan, M.D. 284

President's Page

Anecdotes and political clout 286

Editorial

Conservatism and Medicine 287

Teaching Case

Mountaineer's choice 288

Special Departments

General News 290
Physician's Recognition Awards 293
Continuing Medical Education 296
Medical Meetings/Poetry Corner 297
Bureau of Public Health News 298
Robert C. Byrd Health Sciences Center News 300
MU School of Medicine News 302
Medical Student News 304
Obituary/Society News/New Members 306
Advertising Rates 308
Classified 309
July Advertisers 310

Front Cover

A hiker enjoys the scenic beauty at Babcock State Park in Fayette County. Photo courtesy of *Larry Belcher,* West Virginia Division of Tourism and Parks.

How the Health Care Surrogate Act of 1993 will simplify medical care in West Virginia

ALVIN H. MOSS, M.D.
Director, The Center for Health Ethics and Law, Robert C. Byrd Health Health Sciences Center, West Virginia University, Morgantown

PATRICK D. KELLY, ESQ.
Steptoe & Johnson, Charleston

GIL DELAURA, M.H.A., ESQ.
General Counsel's Office, West Virginia Hospital Association, South Charleston

Editor's Note: *Dr. Moss and Messrs. Kelly and DeLaura are members of the Guardianship Commission of the West Virginia Department of Health and Human Resources which drafted the Health Care Surrogate Act of 1993. The opinions expressed in this article are those of the authors and should not be interpreted as representing the supporting groups, the law firm of Steptoe & Johnson, or the West Virginia Hospital Association. Nothing in this article should be construed as specific legal advice, and if such advice is needed, private counsel should be sought.*

Abstract

The West Virginia Health Care Surrogate Act of 1993 became effective July 1, 1993. This law establishes a process for making health care decisions for adults who lack decision-making capacity and who have not completed a medical power of attorney that does not require judicial involvement. The law describes how a health care surrogate is to be selected by the physician, and it provides immunity to the physician and surrogate who make health care decisions according to its provisions. This article presents a case in which the application of the new law is demonstrated.

Introduction

The West Virginia Legislature passed the Health Care Surrogate Act of 1993 (HCS Act) during its regular session, and the act became effective July 1, 1993. How will it influence the practice of medicine in West Virginia?

To answer this question, consider the hypothetical case of a 71-year-old woman who is admitted to the hospital after a syncopal episode. This patient has been chronically ill with congestive heart failure and lung disease and had been on continuous oxygen at home.

After several days in the hospital during which no apparent cause had been determined for her syncope, she experienced cardiopulmonary arrest. One hour earlier she had been seen by the nurse and was fine. Cardiopulmonary resuscitation was successful in restoring her blood pressure and heart rate to normal. She was intubated and placed on mechanical ventilation in the intensive care unit. This patient did not wake up and showed neurologic signs of a severe hypoxic encephalopathy.

One week later, the patient was unresponsive to painful stimuli. The neurology consultant's assessment was that her neurologic condition was irreversible and was most consistent with a persistent vegetative state. She had never completed an advance directive or talked to anyone about her wishes for future medical treatment. Her doctor thought it would be appropriate to talk to the family about switching the goal of treatment from intensive care with life-prolonging measures including mechanical ventilation to comfort care. The patient's husband was dead, but there were three family members who had visited the patient regularly since admission, a daughter, a brother, and a granddaughter.

The daughter and brother both lived in the same neighborhood as the patient and visited her weekly or more often. They agreed with the doctor's recommendation of a comfort care approach, but the granddaughter who had not seen the patient for over a year prior to this hospitalization requested that "everything possible be done" for her grandmother.

What should the doctor do now?

Description of the law

The HCS Act was written to establish a process for medical decision making for patients like the one in this case, individuals who have not completed a medical power of attorney and who lack decision-making capacity. It grants a surrogate decision maker the authority to make any and all health care decisions on the patient's behalf and describes how the surrogate shall be selected. The HCS Act also gives immunity to physicians and surrogate decision makers who act in accordance with its provisions.

Surrogate decision makers

The law specifies that the physician is charged with the responsibility for selecting a health care surrogate for incapacitated adult patients. Before selecting a surrogate, however, the physician must make a reasonable inquiry as to the existence of a medical power of attorney executed by the patient and the availability of the representative(s) appointed under the patient's medical power of attorney. If a valid medical power of attorney exists and the respresentative is willing to serve, a health care surrogate is not needed and should not be appointed.

When a valid medical power of attorney does not exist or the representative or representatives appointed under the medical power of attorney are unable or unwilling to serve, the physician is to select a surrogate in the following order of priority:

1. The patient's guardian of the person or committee;
2. The patient's spouse;
3. Any adult child of the patient;
4. Either parent of the child;
5. Any adult sibling of the patient;
6. Any adult grandchild of the patient;
7. A close friend of the patient; and
8. Other classes of persons from public or private agencies.

In making this choice, the physician is to determine whether the proposed surrogate is best able to make decisions in accordance with the patient's expressed wishes or, if unknown, in accordance with the patient's best interests. The HCS Act instructs the physician to consider the following criteria in choosing a surrogate:

1) The proposed surrogate's regular contact with the patient prior to and during the incapacitating illness;
2) His or her demonstrated care and concern for the patient; and
3) His or her availability to visit the patient during the illness and to engage in face-to-face contact with the physician for the purpose of fully participating in the decision-making process.

The physician should look for a surrogate from classes in descending order of priority until an appropriate individual is located. The physician should first look for a surrogate from the highest class, i.e., the patient's guardian of the person or committee. In the case presented in this article, the patient does not have either nor does the patient have someone from the next class, a living spouse; therefore, the physician should document these facts and look to the next class, adult children of the patient.

If an adult child meets the surrogate criteria and he/she is willing to serve, the search is over. The daughter met these guidelines in the case described, so the physician may now obtain informed consent from her on behalf of the incapacited patient.

When there are several individuals in a class who are willing to serve, the health care provider must select one of these individuals to serve as the patient's surrogate. For example, if the patient in the case described had four adult children rather than one, the physician must choose the one who appears to be best qualified, and the physician must document the reason for the selection in the patient's medical record.

The HSC Act allows the physician to make an exception from the established order of priority if the physician believes that such person is better qualified to serve as the surrogate based on the criteria given in the HCS Act. For example, if a patient's spouse is estranged and has not seen the patient in over six months, an adult child who has shown care and concern for the patient and had regular contact with the patient, if available, would be better qualified. This example highlights the fact that each case must be examined on an individual basis.

Management of the case

In the case of the 71-year-old woman, there is no guardian or committee, and of the family, the daughter is highest in the priority order and otherwise meets the criteria for selection as the surrogate. The HCS Act provides authorization for the physician to select the daughter as the surrogate decision maker and to make a decision to switch to a comfort-care plan for the patient with the daughter. It provides limited immunity to the physician and to the surrogate in doing so.

Immunity provisions

The immunity provisions of the HCS Act are specific. Recognizing the potential problems associated with the selection of a surrogate decision maker, the Legislature has determined that a health care provider shall not be subject to civil or criminal liability for both the selection of the surrogate decision maker as well as subsequent reliance by the practitioner upon the directions of that surrogate.

This immunity provision is conditional upon good faith compliance by the physician with the provisions of the HCS Act. However, the HCS Act does not relieve the physician of liability for his or her own negligence in the performance of patient care.

Prior to the HCS Act, most physicians, based on our discussions throughout West Virginia, would have continued intensive care for this patient for fear that the granddaughter might sue the physician and the hospital if it was withdrawn. In many such cases, physicians have acknowledged that their continuation of intensive care would have been against their medical judgment. The HCS Act does not prevent the granddaughter from going to court to challenge the appointment of the surrogate, but given the facts in this case it is very doubtful that the granddaughter would successfully prevail.

Conclusion

The HCS Act was drafted by the Guardianship Commission of the Department of Health and Human Resources with input from physicians, nurses, social workers, hospitals, nursing homes, attorneys, patient advocates, and public agencies throughout the state. The intent of the West Virginia Legislature in passing the HCS Act was to establish a process for private decision making for patients who lacked decision-making capacity and a medical power of attorney that would not require court involvement.

Hopefully, this new act will simplify the practice of medicine for these patients and allow health care decisions to be made expeditiously by individuals who know the patient best and who can make the decisions that the patient would have made if able to do so.

Sexual Misconduct Statement of the West Virginia Board of Medicine [1]

Editor's Note: *This statement is published at the request of the West Virginia Board of Medicine.*

. . . ENTER ONLY FOR THE GOOD OF THE PATIENT . . . KEEP YOURSELF FAR FROM ALL SEDUCTION AND ESPECIALLY THE PLEASURES OF MEN AND WOMEN . . . (2)

The prohibition against sexual contact between a physician and a patient is well established and is embodied in the oath taken by all physicians, the Hippocratic Oath. The reason for this proscription is the awareness of the adverse effects of such conduct on patients. The report of the Council on Ethical and Judicial Affairs of the American Medical Association indicates that most researchers now agree that the effects of physician-patient sexual contact are almost always negative or damaging to the patient. Patients are often left feeling humiliated, mistreated or exploited (3).

Further, a patient has a right to trust and believe that a physician is dedicated solely to the patient's best interests. Introduction of sexual behavior into the professional relationship violates this trust because the physician's own personal interests compete with the interests of the patient. This violation of trust produces not only serious negative psychological consequences for the individual patient but also destroys the trust of the public in the profession (3).

Sexual contact with a patient occurs in many circumstances ranging from situations where a physician is unable to effectively manage the emotional aspects of the physician-patient relationship to consciously exploitative situations. Underlying most situations is a disparity of power and authority and a physically or emotionally vulnerable patient (3).

The prohibition against sexual contact between a physician and a patient is not intended to inhibit the compassionate and caring aspects of a physician's practice (3). Rather, the prohibition is aimed at behaviors which overstep the boundaries of the professional relationship. When boundaries are violated, the physician's patient may become the physician's victim. The physician is the one who must recognize and set the boundaries between the care and compassion appropriate to medical treatment and the emotional responses which may lead to sexual misconduct. It is the physician's responsibility to see that sexual intimacies do not occur.

The West Virginia Board of Medicine is charged with the duty of protecting the public against the unprofessional actions of physicians licensed to practice medicine and surgery in West Virginia. The West Virginia Medical Practice Act states that a physician may be disciplined for exercising influence within a patient-physician relationship for the purpose of engaging a patient in sexual activity. Also, the rules of the West Virginia Board of Medicine state that it is unprofessional conduct to fail to conform to the principles of medical ethics of the American Medical Association. The Current Opinions of the Council on Ethical and Judicial Affairs of the AMA state on the subject of sexual misconduct in the practice of medicine:

> *Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.*
>
> *If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic or sexual relationship with a patient.*
>
> *Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.*

The writing of a prescription for a person may be enough to establish a patient-physician relationship. A patient is presumed to remain a patient until the patient-physician relationship is terminated. The fact that a person is not actively receiving treatment or professional services is not determinative of whether a patient-physician relationship is terminated.

Once a physician-patient relationship has been established, the physician has the burden of showing that the relationship no longer exists. The mere passage of time since the patient's last visit to the physician is not solely determinative of the issue. Some of the factors in determining whether the physician-patient relationship has terminated include, but are not limited to, the following: formal termination procedures; transfer of the patient's care to another physician; the reasons for wanting to terminate the professional relationship; the length of time that has passed since the patient's last visit to the physician; the length of the professional relationship; the extent to which the patient has confided personal or private information to the physician; the nature of the patient's medical problem; the degree of emotional dependence that the patient has on a physician . . . ; the extent of the

physician's general knowledge about the patient (3).

Some physician-patient relationships may never terminate because of the nature and extent of the relationship. These relationships may always raise concerns of sexual misconduct whenever there is sexual contact.

Sexual contact between a physician and a former patient after termination of the physician-patient relationship may still subject the physician to discipline under the West Virginia Medical Practice Act if the sexual contact is a result of exercising influence within a patient-physician relationship for the purpose of engaging a patient in sexual activity.

The Board of Medicine's responsibility to ensure that the public is protected from future misconduct is consistent with the Board's actions in sexual misconduct cases. In some cases, revocation is the only means by which the public may be protected. In other cases, the Board of Medicine may restrict and monitor the practice of a physician who is actively engaged in a rehabilitation program. Rehabilitation of a physician is a secondary goal that may be pursued if the Board is assured that the public is not at risk for recurrence of the misconduct.

The Board reminds physicians of their legal duty to report sexual misconduct or any act which may constitute unprofessional conduct or which may indicate that a physician is unable to practice medicine with reasonable skill or safety to patients. It is the physician's responsibility to maintain the boundaries of the professional relationship by avoiding and refraining from sexual contact with patients. To this end, the Board of Medicine strongly recommends the following:

1. Physicians should be alert to feelings of sexual attraction to a patient and may wish to discuss such feelings with a colleague. To maintain the boundaries of the professional relationship, a physician should transfer the care of a patient to whom the physician is attracted to another physician and should seek help in understanding and resolving feelings of sexual attraction without acting on them.
2. Physicians must be alert to signs indicating that a patient may be encouraging a sexual relationship and must take all steps necessary to maintain the boundaries of the professional relationship including doing nothing to encourage this behavior and transferring the patient.
3. Physicians must respect a patient's dignity at all times and should provide appropriate gowns and private facilities for dressing, undressing and examination.
4. To minimize misunderstandings and misperceptions between a physician and patient, the physician should explain the need for each of the various components of an examination and for all procedures and tests.
5. Physicians should choose their words carefully so that their communications with a patient are clear, appropriate and professional.
6. Physicians should seek out information and formal education in the area of sexual attraction to patients and sexual misconduct and should in turn educate other health care providers and students.
7. Physicians should not discuss their intimate personal problems with patients.
8. Physicians should remember that treatment boundaries tend to erode gradually and that once a sexual relationship begins it may be impossible to terminate without serious consequences for both parties.

Adopted by:
West Virginia Board of Medicine
Eileen Catterson, M.D., President
Date 5-17-93

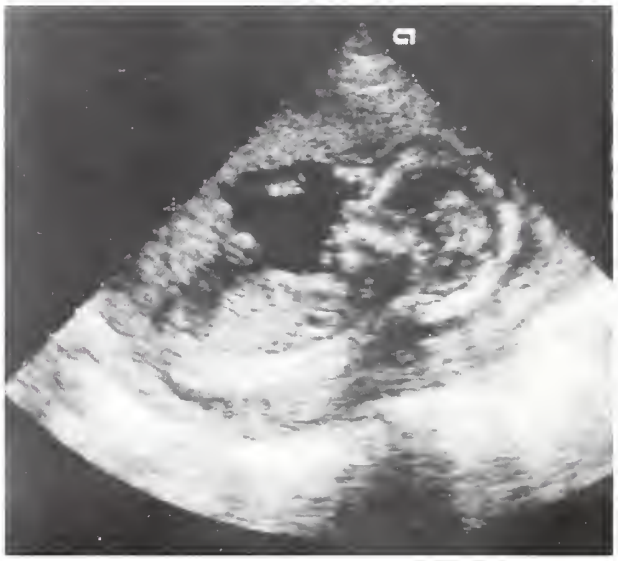
References

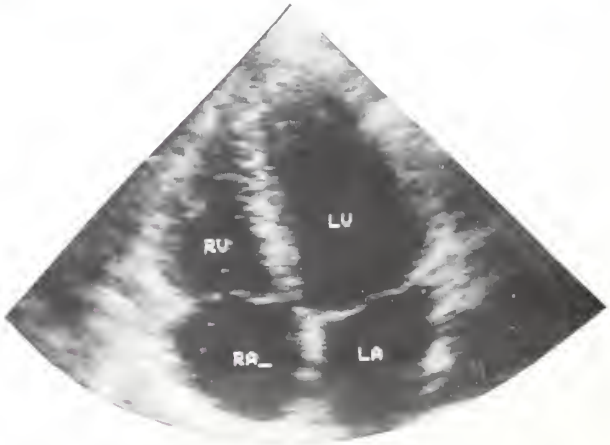
1. This statement has borrowed liberally from the Washington State Medical Disciplinary Board's Sexual Misconduct Statement and Policy of the Medical Disciplinary Board, which was adopted by the Washington State Medical Disciplinary Board in 1992.
2. Dreiblatt I. Health care providers and sexual misconduct. Federation Bulletin 1992 Jan:8-14.
3. American Medical Association, Council on Ethical and Judicial Affairs. Sexual misconduct in the practice of medicine. JAMA 1991;266(19).

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time





Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

WESPAC

West Virginia State Medical Association's
Political Action Committee

With so many challenges facing organized medicine, it is imperative that we have support in the Legislature. The need for political action has never been greater!

Write your personal check to WESPAC today and help us strengthen our role in the legislative process.

$50 - Regular **$100 - Sustainer**
$150 - Extra Miler

Mail your personal check to:

WESPAC
P.O. Box 4106
Charleston, WV 25364

An implication for bone posterity: Dietary calcium intake in medical personnel in southern West Virginia

ALFRED K. PFISTER, M.D., F.A.C.P.
Clinical Professor of Medicine, West Virginia University Health Sciences Center, Charleston Division; and CAMC Ambulatory Care Center

Abstract

Osteoporosis in the postmenopausal and elderly years is caused by a multitude of factors, which include calcium intake, and is felt largely to be a preventable situation. Low dietary calcium intakes (505 mgs. daily) are common in middle-aged females in southern West Virginia. Further information about the demographic factors in the elderly population from all socioeconomic groups needs to be explored to effect changes in dietary lifestyles.

Introduction

Recent studies have shown that higher calcium intakes improve bone density measurements in children (1) and young adults up to the age of 30 (2). The RDA (Recommended Daily Allotment) for calcium in an adult is 800 mgs., but values should be higher during pregnancy, lactation, and adolescence. It has been proposed, based on metabolic-balance studies, that these values are too low and that premenopausal women should consume at least 1,000 mgs. of daily calcium (3).

Methods

A preliminary survey of a group of female medical personnel (nurses, medical students, medical residents, and nursing aides) was undertaken in the ambulatory care clinics to determine what recommendations to make in nutritional counseling in southern West Virginia. A food frequency questionnaire which shows good correlation with a four-day food intake was employed to determine daily calcium intake (4).

Subjects were chosen on a non-probability convenience basis since it was assumed that a higher socioeconomic group of medically knowledgeable participants, who were free of chronic illnesses and restricted diets, should display a fairly good calcium intake. All persons were interviewed after completing the intake form to validate the accuracy of their responses. The results of each form were quantitated for calcium content by the values listed in Pennington's Food Values manual (5).

Results

A total of 30 subjects were interviewed; one was excluded in the final analysis because of incomplete data. All participants were white except two; the mean age was 40.6 years (range 28 to 62). The mean 24-hour calcium intake was 505.7 mgs. (range 125 to 1,247). A linear regression analysis showed poor correlation with body mass indices (Kg/m^2).

Discussion

Osteoporosis is largely an asymptomatic illness until bone fractures occur. After menopause, the incidence of fractures increases to 20% at the age of 65 and then progresses as high as 40% in the subsequent years. Hip fractures are particularly devastating, with an estimated cost of over $7 billion annually. Over half of the patients who experience this type of fracture never walk again despite surgery and physical therapy (6).

The vast majority of the subjects in this study group are already in negative calcium balance prior to entry into menopause (Figure 1). Prevention of osteoporosis is clearly a cost-effective goal and has been selected as one objective by the Public Health Service, Department of Health and Human Services, by the year 2000 (7). Enough medical information has been formulated to slow down bone

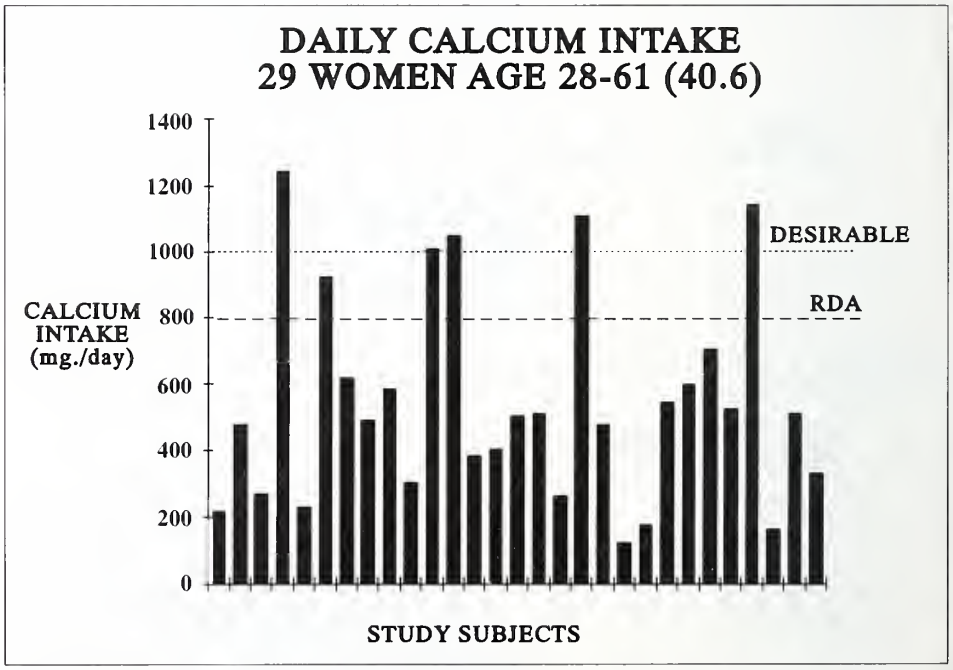


Figure 1. Daily calcium intakes by diet in middle-aged women in southern West Virginia.

loss by screening techniques, weight-bearing exercises, estrogen administration, vitamin D therapy, and nutritional (calcium) intervention (3). Certain subsets may benefit from a prevention program more than others since osteoporosis is a multi-factorial disease.

The use of calcium supplementation or increased calcium-containing food consumption in patients whose calcium intakes are low or marginal should be beneficial. The results of this study indicate that only six out of 29 subjects had daily calcium intakes above the daily RDA of 800 mgs., and only four out of 29 individuals had intakes above the desirable intake of 1,000 mgs. per day. The RDAs are supposedly set high enough in order that most people with high needs are protected; however, optimal levels are not portrayed in this value. In some groups, such as the adolescents and the elderly, nutritional data concerning the RDA on various minerals are limited (8).

Heaney and colleagues conducted calcium balance studies in 130 middle-aged women and found that at least 1,200 mgs. or more of dietary calcium was needed to maintain a positive calcium balance (9). Calcium balance studies conducted by Nordin and colleagues yielded evidence that 900 mgs. of daily calcium intake was needed to ensure adequate balance in 95% of adults, and that this requirement be increased in the postmenopausal years (10). It is apparent that these higher desired values of calcium intake refute the RDA of 800 mgs.

The question remains how relevant is a low intake of dietary calcium in the development of osteoporosis. Arnaud, after reviewing the pertinent literature, noted that dietary calcium, when low, played a permissive role in establishing the osteoporotic syndromes; however, osteoporosis still occurred when dietary calcium consumption was adequate. An international survey was cited which showed an inverse relationship to dietary calcium and osteoporotic vertebral fractures among countries (11). Animal studies clearly link calcium deficiency as a cause of osteoporosis indistinguishable from human osteoporosis (10). If such epidemiological evidence incriminates a calcium deficiency state as a factor in osteoporosis, then increased dietary calcium or supplemental calcium intakes should ameliorate this condition.

Experimental evidence exists which supports the hypothesis that increasing calcium intake improves the health of bone. Bone density improved over a six-month period in a group of elderly patients whose baseline diet had inadequate calcium content by adding calcium-rich foods (12). Calcium supplements reduced the rate of bone re-absorption in postmenopausal women, but not as effectively as concomitant calcium and estrogen administration (13). A study in a group of postmenopausal women with a low intake of dietary calcium showed calcium supplements significantly reduced bone loss on the radius in the early postmenopausal group (14). Other studies reviewed by Arnaud (11), which were conducted for longer periods of time, indicated calcium supplements improved measurements of metacarpal bone but not always radial and trabecular bone (vertebrae and hip). It appears that calcium supplements, although beneficial, are most useful if dietary calcium intake has been low or if estrogens have been given concomitantly in the postmenopausal patients.

Elderly patients not only may suffer from reduced dietary calcium intake but also impaired calcium absorption. Levels of 1,25-dihydroxyvitamin D, the active metabolite of Vitamin D which controls calcium absorption, are low in postmenopausal women. This is most likely caused by a prolonged loss of calcium from bone which causes a slight elevation of serum calcium, and thereby results in a suppression of parathormone secretion and 1,25-dihydroxyvitamin D synthesis. Supplemental Vitamin D and calcium are indeed effective in restoring bone density, total body calcium stores, and reducing hip fractures (15,16).

This study group, headed into menopause, has a diet with insufficient calcium intake. The extent of dietary calcium deficiency in southern West Virginia is unknown. A study is currently underway to obtain this information involving a large number of subjects over the age of 65 from all socioeconomic groups to correlate the quantity of calcium intake with various psychosocial factors. It is anticipated this study will provide insight on how to implement ways to achieve a positive calcium balance.

Acknowledgements

Appreciation is expressed to Diane Salamie, R.D., for questionnaire advice; to Jay Zhang, Ph.D., for statistical analysis; and to Harold Selinger, M.D., for data presentation.

References

1. Johnston CC, Miller JZ, Slemenda CW, et al. Calcium supplementation and bone mineral density in children. New Engl J Med 1992; 327:82.
2. Recker RR, Davies KM, Hinders SM, et al. Bone gain in young adult women. JAMA 1992;268:2403.
3. Riggs BL, Melton LJ. The prevention and treatment of osteoporosis. New Engl J Med 1992;327:620.
4. Musgrave KO, Giambalvo L, Leclerc HL, et al. Validation of quantitative food frequency questionnaire for rapid assessment of dietary calcium intake. J Am Diet Assoc 1989;89:1484.
5. Bowes A, Church CF. Food values of portions commonly used. New York: Jean AT Pennington, 1937; revised, Harper Perennial, a division of Harper Collins Publisher, 1989.
6. Melton LJ, Riggs BL. Epidemiology of age-related fractures. In: Avioli LV, editor. The osteoporotic syndrome. Orlando: Grune and Stratton, Inc, 1987:1-30.
7. Department of Health and Human Services. Healthy People 2000. National Health Promotion and Disease Prevention Objectives. Boston: U.S. Dept. of Health and Human Services, Public Health Service, 1992.
8. Robinson CH, Lawler MR, Chenoweth WL, Garwick AE. Normal and therapeutic nutrition. New York: MacMillan, 1990.
9. Heaney RP, Recker RR, Saville PD. Calcium balance and calcium requirements in middle-aged women. Am J Clin Nutr 1977; 30:1603.
10. Nordin BEC, Horsman A, Marshall DH, et al. Calcium requirement and therapy. Clin Orthop 1979;140:216.
11. Arnaud CD. Role of dietary calcium in osteoporosis. Advances in Internal Medicine 1990;35:93.
12. Lee CJ, Lawler GS, Johnson GH. Effects of supplementation of the diets with calcium and calcium-rich foods on bone density of elderly females with osteoporosis. Am J Clin Nutr 1981;34:819.
13. Recker RR, Saville PD, Heaney RP. Effect of estrogens and calcium carbonate on bone loss in postmenopausal women. Ann Int Med 1977;87:649.
14. Dawson-Hughes B, Dallal GE, Krall EA, et al. A controlled trial of the effect of calcium supplementation on bone density in postmenopausal women. New Engl J Med 1990;323:878.
15. Tilyard MW, Spears GFS, Thomson J, Dovey S. Treatment of postmenopausal osteoporosis with calcitriol or calcium. New Engl J Med 1992;326:357.
16. Chapuy MC, Arlot ME, Duboeuf F, et al. Vitamin D3 and calcium to prevent hip fractures in elderly women. New Engl J Med 1992;327:1637.

Papillary intraperitoneal neoplasia resembling ovarian carcinoma after removal of benign ovaries

CURTIS D. WHITE, M.D.
Department of Obstetrics and Gynecology, Marietta Memorial Hospital, Marietta, Ohio

Abstract

Ovarian cancer continues to be a major cause of death in women since there are no reliable screening methods and because symptoms usually do not appear until the disease has progressed to Stage III or IV, when the chances of cure are very poor. Prophylactic oophorectomy is being considered by some physicians for any woman undergoing hysterectomy after age 40-45. Even with the removal of benign ovaries, intraperitoneal carcinomatosis histologically resembling ovarian cancer can occur. This article describes a case of primary papillary intraperitoneal neoplasia resembling serous adenocarcinoma of the ovary which presented two years after removal of benign ovaries.

Introduction

Ovarian carcinoma continues to be a major cause of death in women. It is estimated that in 1992, there were 21,000 new cases of ovarian carcinoma and 13,000 deaths in this country (1). One of every 70 women (1.4%) will develop ovarian carcinoma in her lifetime.

Since there are no reliable screening methods and because symptoms usually do not appear until the disease has progressed, most patients will present as Stage III or IV (2,3). The chances of cure are then very poor.

Some physicians have recommended that prophylactic oophorectomy be considered for any woman undergoing hysterectomy after age 40-45. If a woman has two first-degree relatives with ovarian carcinoma, her risk of developing the disease may be as high as 50% (4,5). In these cases, prophylactic oophorectomy should be strongly considered after completion of childbearing.

Even with the removal of benign ovaries, intraperitoneal carcinomatosis histologically resembling ovarian carcinoma can occur (8). This article reports a case of primary papillary intraperitoneal neoplasia resembling serous adenocarcinoma of the ovary presenting two years after removal of benign ovaries.

Case Report

At age 63, a white female who was GIII PIII underwent an endometrial curettage for postmenopausal spotting. The pathology report revealed atypical hyperplasia, suggestive of adenocarcinoma in situ. She subsequently underwent an abdominal hysterectomy with bilateral salpingo-oophorectomy, and histology showed benign ovaries and only focal adenocarcinoma in situ of the uterine fundus.

Two years later, while living in another state, this woman developed a flu-like illness with intermittent GI distress. A barium enema showed a narrowing of the sigmoid colon. A subsequent laparotomy showed diffuse peritoneal spread of a papillary serous adenocarcinoma consistent with ovarian carcinoma surgical Stage III C. She had a suboptimal resection of disease and was started on chemotherapy with cisplatin and Cytoxan.

After three courses of chemotherapy, this patient returned to the Marietta area and was continued on the same chemotherapy for four more courses given at three-week intervals. Recuts of the ovaries from the hysterectomy two years prior confirmed benign tissue. She developed some minor peripheral neuropathy, which was thought to be secondary to cisplatin.

For the next three courses of treatment, this patient received Cytoxan. With her 11th course of treatment, cisplatin was resumed at 40 mgs./m^2 (80% of the original dosage). She continued to do well, and her weight and nutrition gradually improved. Her CA-125 level, initially at 125 U/ml. had dropped to 11.4 (normal < 35). An MRI scan performed at this time (now 13 months after her original diagnosis) was negative.

Due to this patient's age and health, she chose not to have a "second look" laparotomy. Plans were to continue on maintenance chemotherapy every six weeks. However, she returned to another state and her physician there elected not to continue chemotherapy. Within six months, her CA-125 level had risen to 2,275 U/ml. She returned to the Marietta area and was begun on cisplatin and VP-16, then later changed to carboplatin and Megace. She had an initial response with her CA-125 dropping to 442 and was clinically improved. Thereafter, her condition deteriorated and she died 22 months after her initial diagnosis.

Discussion

Ovarian carcinoma remains the leading cause of death among gynecologic malignancies in the United States (1). Although the majority of patients will have an initial response to platinum-based combination chemotherapy, the five-year survival in advanced disease remains poor. Most are diagnosed as Stage III or IV and fewer than 25% - 30% will survive (2,3). While the new drug Taxol has received a lot of attention and has produced up to a 32% response rate in patients who are pretreated heavily, it has as yet not altered survival.

Although several risk factors for ovarian carcinoma have been identified, a high-risk population has not been well defined (6). The familial ovarian carcinoma syndrome appears to be autosomal dominate with incomplete penetrance (7). This has led to the recommendation of prophylactic oophorectomy after childbearing in women with a strong family history of ovarian carcinoma to prevent ovarian cancer from developing (8).

However, cases have been reported where intra-abdominal carcinomatosis developed even after removing the ovaries (8). There are several explanations for the development of papillary peritoneal neoplasia resembling ovarian carcinoma, including ectopic ovarian tissue, malignant transformation of the peritoneum and undetected ovarian carcinoma at the time of oophorectomy (1). Interestingly, the peritoneum and the germinal epithelium covering the ovary are both derived from the coelomic epithelium.

While the occurrence of papillary peritoneal carcinoma resembling ovarian carcinoma with benign ovaries is very rare, it is recommended that patients undergoing prophylactic oophorectomy for the prevention of ovarian carcinoma undergo a thorough intra-abdominal search for occult intraperitoneal neoplasia.

References

1. Boring CC, Squires TS, Tong T. Cancer statistics, 1992. CA A Cancer J Clin 1992;42:19.
2. Ozols RF. Ovarian cancer. Semin Surg Oncol 1990;6:328.
3. Thigpen TJ, Blessing JA, Vance RB, Lambuth BW. Chemotherapy in ovarian carcinoma: Present role and future prospects. Semin Oncol 1989:16:58.
4. Piver MS, Curtis JM, Tsukada Y, Nasca P, Greenwald P. Familial ovarian cancer registry. Obstet Gynecol 1984;64:195.
5. Piver S. Buffalo (NY): The Gilda Radner Familial Ovarian Cancer Registry Newsletter. Rosewell Park Cancer Institute, 1990.
6. Runowicz CD. Advances in screening and treatment of ovarian cancer. CA A Cancer J Clin 1992;42:327.
7. Lynch HT, Bewtra C, Lynch J. Familial ovarian carcinoma. Am J Med 1986;81:1073.
8. Kemp GM, Hsiu JG, Andrews MC. Papillary peritoneal carcinomatosis after prophylactic oophorectomy. Gynecol Oncol 1992;47:395.

Breast-Conservation Treatment

AT LEAST ONE-THIRD OF ALL BREAST CANCER PATIENTS COULD HAVE LUMPECTOMY FOLLOWED BY RADIATION THERAPY

The American Cancer Society, the American College of Surgeons and the American College of Radiology have agreed that women whose early breast cancer was detected by mammography are candidates for breast-saving treatment. According to new standards, women with small lumps, those with tumors as large as two inches, and even some women with positive nodes may be candidates for this treatment.

Stage for stage, patients treated in this manner have the same longevity and the same freedom from local recurrence as those treated with mastectomy.

For copies of the standards please contact Keri Sperry, American College of Radiology, 1891 Preston White Drive, Reston, VA 22091.

acr

AMERICAN COLLEGE OF SURGEONS

AMERICAN CANCER SOCIETY®

Report of *Pseudomonas aeruginosa* sinusitis in a patient with AIDS

R. WESLEY FARR, M.D.
Section of Infectious Diseases, Department of Medicine and Department of Otolaryngology, School of Medicine, Robert C. Byrd Health Sciences Center, West Virginia University, Morgantown

HASSAN H. RAMADAN, M.D.
Department of Otolaryngology, School of Medicine, Robert C. Byrd Health Sciences Center, West Virginia University, Morgantown, West Virginia

Abstract

Pseudomonas aeruginosa can cause infections in AIDS patients who frequently do not have the usual predisposing conditions such as neutropenia and intravenous drug use. The infections due to P. aeruginosa may be difficult to treat in AIDS patients. Sinusitis has been increasingly recognized as a complication in patients with AIDS. This article describes a case of recurrent P. aeruginosa sinusitis which, until recently, was rarely reported in AIDS.

Introduction

Infections due to *Pseudomonas aeruginosa* in patients with human immunodeficiency virus (HIV) infection have become more frequently recognized recently (1,2). An interesting feature of these infections has been the infrequent occurrence of the usual identified risk factors for *P. aeruginosa* infection, such as neutropenia and intravenous drug use (IVDU) (1).

Sinusitis is being increasingly recognized as a complication of HIV infection and acquired immunodeficiency syndrome (AIDS) (3-8). In earlier reviews of bacterial complications of AIDS, sinusitis due to *P. aeruginosa* was rarely reported (9,10). Recent reviews document this pathogen as an important pathogen in sinusitis in AIDS patients (7,8); and in this article we present a case of chronic recurrent sinusitis due to *P. aeruginosa* in a patient with AIDS.

Case Report

A 39-year-old white bisexual man was admitted to the hospital in November 1991 for treatment of *P. aeruginosa* sinusitis. He was diagnosed with AIDS in May 1991 with disseminated *Mycobacterium avium-intracellulare* infection and chronic mucocutaneous Herpes simplex type 2 infection.

This patient's CD4 lymphocyte count on initial presentation in May 1991 was 20/mm.^{3} A month later, he developed anemia after beginning zidovudine (Retrovir, AZT) and refused to take further zidovudine or didanosine (Videx, ddI). Cytomegalovirus chorioretinitis was detected in August 1991, and he also refused to take ganciclovir (Cytovene). He, therefore, had not developed neutropenia at any time prior to his diagnosis of infection with *P. aeruginosa*. In addition, this patient had received courses of antibiotics during two hospitalizations in the three months prior to his admission for sinusitis for treatment of pneumonitis of undetermined etiology, and had also received oral antibiotics as an outpatient for treatment of sinusitis without improvement.

On admission in November 1991, he complained of profuse nasal discharge and a cough productive of yellow sputum. Peripheral white blood cell count was 6,800/mm.^{3} with 66% neutrophils and 8% bands. A computerized tomography scan of the sinuses documented bilateral ethmoid and maxillary sinusitis. Sputum and nasal swab cultures grew *P. aeruginosa* sensitive to gentamicin and ticarcillin. He received a two-week course of intravenous antibiotics with gentamicin and ticarcillin which lessened his nasal discharge and cough.

This patient underwent surgical treatment on two occasions. Endoscopic bilateral total ethmoidectomies and sphenoidectomies with maxillary antrostomies were planned for December 30, 1991; however, due to profound bleeding and inadequate visualization, the procedure was terminated after only bilateral anterior ethmoidectomies. On January 20, 1992, these planned procedures were performed. A right Caldwell-Luc procedure was performed at this time because endoscopic cleaning of the right antrum was not feasible.

Following his initial admission for sinusitis, this patient had eight subsequent admissions through October 1992 for recurrences of *P. aeruginosa* sinusitis that improved with two weeks of intravenous therapy with an aminoglycoside and an anti-pseudomonal *B*-lactam antibiotic. Multiple nasal swab and sputum cultures were positive for *P. aeruginosa*.

His course was complicated by the development of neutropenia in March 1992 after he began taking ganciclovir in January and zidovudine in April 1992. Chronic suppressive therapy with oral ciprofloxacin (Cipro) was not an option because of previous adverse effects while taking this antibiotic. He died from progressive pneumonitis of undetermined etiology in November 1992.

Discussion

Sinusitis due to *P. aeruginosa* is being increasingly recognized as a complication of HIV infection and AIDS (3-8). This patient did not have many of the classic risk factors for *P. aeruginosa* infection such as neutropenia or IVDU, but was predisposed to this infection because of hospitalizations and antibiotic usage.

His *P. aeruginosa* infection was difficult to treat consistent with previous reports of poor response in patients with advanced HIV infection (1,2,7,10). Chronic suppressive antibacterial therapy may be useful in some patients with recurrent or chronic *P. aeruginosa* sinusitis (10). However, ciprofloxacin-resistant strains of *P. aeruginosa* have been reported in patients taking ciprofloxacin for disseminated *Mycobacterium avium* complex infections (8).

References

1. Kielhofner M, Atmar RL, Hamill RJ, Musher DM. Life-threatening *Pseudomonas aeruginosa* infections in patients with human immunodeficiency virus infection. Clin Infect Dis 1992;14:403-11.
2. Lozano F, Corzo JE, Nogales C, Garcia-Bragado F. Life-threatening *Pseudomonas aeruginosa* infections in patients with human immunodeficiency virus infection. Clin Infect Dis 1992;14:751-2.

3. Rubin JS, Honigberg R. Sinusitis in patients with the acquired immunodeficiency syndrome. Ear Nose Throat J 1990;69:460-3.
4. Senneville E, Chevalier D, Ajana F, Lecocq P, Chidiac C, Mouton Y. Management of acute sinusitis in people with HIV (abstract no. PoB 3332). VIIIth International Conference on AIDS/III STD World Conference. Amsterdam, The Netherlands. 1992;2:B142.
5. Fineman DS, Palestro CJ, Kim CK, Needle LB, Vallabhajosula S, Solomon RW, et al. Detection of abnormalities in febrile AIDS patients with In-111-labeled leukocyte and Ga-67 scintigraphy. Radiology 1989;170:677-80.
6. Zurlo JJ, Feuerstein IM, Lebovics R, Lane HC. Sinusitis in HIV-1 infection. Am J Med 1992; 93:157-62.
7. Godofsky EW, Zinreich J, Armstrong M, Leslie JM, Weikel CS. Sinusitis in HIV-infected patients: a clinical and radiographic review. Am J Med 1992;93:163-70.
8. Sinusitis due to *Pseudomonas aeruginosa* in patients with human immunodeficiency virus infection. Clin Infect Dis 1993;16:404-6.
9. Poole MD, Postma D, Cohen MS. Pyogenic infections in acquired immune deficiency syndrome. Arch Otolaryngol 1984;110:130-1.
10. Schrager LK. Bacterial infections in AIDS patients. AIDS 1988;2(1 suppl):183S-9S.

New Manuscript Guidelines

All scientific manuscripts should be submitted on disc in the following languages: Wordperfect 4.2, 5.0, and 5.1; Word; Word for Windows; and WordStar. They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

No more than 25 references will be published free of charge and they must be presented in the style based on the formats used by the U.S. National Library of Medicine in *"Index Medicus."*

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

LEONARDO COULD HAVE QUALIFIED FOR AMWA MEMBERSHIP. CAN YOU?

The great Renaissance man could have made it on the strength of his medical writing alone...
Or as an illustrator,
Or simply as a medical scientist.
You can earn membership in the American Medical Writers Association — AMWA— by being any one of these, as well as by being a doctor, dentist, editor, librarian, educator, medical photographer... or by being professionally involved in medical communication.
The one inflexible criterion: you must share the conviction of AMWA's 3,700 members that clear, concise communication is a vitally important art that must be cultivated and refined.
To achieve that end, AMWA conducts extraordinary workshops, plenary sessions and forums in a variety of specialized facets of communications — including explorations into the latest electronic media. It holds local, regional, national, and international meetings that enable writers, editors, physicians, film- and videomakers, publishers, illustrators — a wide spectrum of scientific communicators to meet and exchange ideas. And AMWA publishes a refereed journal that exists for one purpose only — to encourage and nurture concise, lucid medical communications.
To learn more about how to join the rapidly growing ranks of AMWA members who share your concerns, write, call, or fax the American Medical Writers Association, 9650 Rockville Pike, Bethesda Maryland 20814, (301-493-0003, fax 301-493-0005).
Just because da Vinci missed out on AMWA membership is no reason you should!

AMERICAN MEDICAL WRITERS ASSOCIATION

President's Page

Robert P. Pulliam MD.

Anecdotes and political clout

Hillary Rodham Clinton spoke for almost an hour at the recent opening session of the AMA House of Delegates in Chicago. The topic -- health care, of course.

The event, which was obviously scheduled at the last minute and probably a result of David Gergen's recent directions for the White House, was attended by an overflow crowd. The speech was long, short on substance and occasionally interrupted by polite applause.

Mrs. Clinton used medical anecdotes to bring forth the need for health care reform. These included emotional stories of doubtful substance such as one about a woman in a rural southern state who visited her physician about a breast mass and was told that since she did not have insurance that it could probably be watched for several months before intervention. The implication was that the woman had breast cancer and was denied treatment because she could not pay.

When I listened to this story, my thoughts returned to the numerous occasions I have discussed with patients the problems, the possibilities for diagnosis, the modes of treatment, the potential costs of each alternative, and the risks and benefits of each. Granted, it is a lot of information and a stressful period for the patient. Together, the patient and the physician must make a decision about the correct course to follow. The physician documents this and the patient leaves.

This type of event occurs thousands of times a day in this country. Qualified, caring, compassionate physicians perform an excellent job. Numerous studies have demonstrated poor recall by patients of events of this nature. Physicians understand this and strive to involve the patient in his/her health care to the maximum extent possible.

No one will ever really know the actual details about the case of the woman with the breast mass and other stories Mrs. Clinton described, and the continuing use of this negative type of anecdote by her and the press will continue to harm the body of medicine and the American health care system.

Physicians need to use real life situations to counter these anecdotal charges. For example, a single obstetrician gynecologist, Dr. Alex Wanger, provided delivery services to over 450 patients last year in the Eastern Panhandle of West Virginia. This is more than three times the workload of the average physician.

Why did he do it? Because he cares! Anyone who knows Alex understands this, particularly his patients!

In addition to discussing the topic of questionable anecdotes this month, I must express to you some figures which relate to political clout. The spring 1993 West Virginia Trial Lawyers' newsletter *"The Advocate"* listed annual giving to WVTLA/LAWPAC, their political action committee. Total giving was calculated at a minimum of $135,300, as compared to a total of $13,450 which was given to WESPAC by WVSMA members this year!

A comparison of the categories and amounts given to both LAWPAC and WESPAC are listed below. As you study these figures in this chart, do they suggest to you the reason for our failures in the legislative arena?

Robert P. Pulliam, M.D.

1993 West Virginia Trial Lawyers Association's LAWPAC Contributions

Categories	Number of Donations	Totals
Supporter $500	7	$ 700
Friend $500-$899	7	$ 3,500
Patron $900-$1,199	23	$ 20,700
Amicus $1,200-$2,399	54	$ 64,800
Advocate $2,400-$3,599	10	$ 24,000
Barrister $3,600-$4,799	6	$ 21,600
Fellow $4,800-$7,199		
Founder $7,200 and over		
		$135,300

1993 West Virginia State Medical Association's WESPAC Contributions

Categories	Number of Donations	Totals
Regular $50-$99	105	$ 5,250
Sustainer $100-$149	37	3,700
Extra-Miler $150 and over	29	4,500
		$ 13,450

Conservatism and Medicine

Editor's Note: *This month we are reprinting an editorial which appeared in the February 1973 issue of the West Virginia Medical Journal that we feel is still very relevant today.*

It seems that some doctors are embarrassed by the *conservative* label attached to Medicine. Advocates of liberal causes, to further their ends, make steady attempts in a tactical effort to attach to conservatism unwholesome connotations such as reactionaryism or obstructionism. The impression given is that it is very fashionable and very intellectual to be liberal in one's views. Vanity alone inclines some doctors to include themselves amongst the intellectuals.

A gauge of the success of this tactical maneuver is the embarrassment noted above. The result, of course, is an unwillingness to be involved in active resistance to liberal schemes by some who might otherwise find themselves in genuine disagreement.

To be consistent with their convictions, most doctors are willing to risk the judgment of being considered unfashionable in their views and to ignore the intimidation of being considered simian in their mentality. They know that conservatism does not imply a total and complete resistance to change, a return to "the good old days and the good old ways." They realize that to be conservative means simply to have the capacity to be selective in culling through that haze of brainstorms which rise like so many heat waves from the fevered brains of professional liberals.

Most conservatives would profess the belief that occasionally an apparently good idea for change does arise. Once perceived, such an idea must be tested in the crucible of conservative doubt and criticism. It must be held in the flame of partisan debate. Its frailties and weaknesses must be exposed. Its end results and its byproducts, both good and bad, must be placed in the balance scales. Having passed such an ordeal, an idea may be considered hardy, indeed, and deserving of a cautious trial in practice. It is the role and function of conservative thought and the responsibility of conservative thinkers to resist change, to question proposals for change, and in the process to refine them to the point of extinction or to the extent they may be of benefit to the intended beneficiaries.

The disarray of many of our domestic programs is as much an indictment of conservatives for having failed to mount an effective resistance as it is of liberals for having proposed the failing schemes to start with. Responsible conservatives recognize that change is not only inevitable but even necessary. Recognition of the need for change, however, is simply no reason to accept *any* proposal for change in Medicine or in any other field.

Medicine has no need to be apologetic about the number or the extent of changes in the way Medicine has been practiced over any given time period. We can take pride in the fact that the changes we have supported and put into effect have been good for those we serve, and that the accuracy of warnings and criticisms we have expressed about other changes thrust on us has been borne out in practice.

We have been conscientious and responsible toward our obligation to provide medical care. Our course has been consistently in the direction of progress. We have accomplished this by our willingness to challenge anyone who has leaped up with the cry of, "Forward!" It has been reported that skindivers at night are unable to determine from their own sensory apparatus which way is up and that some, not trusting their instruments, swim down and down, all the while thinking they are heading to the safety of the surface.

We, too, operate in such a murk. Medicine has been and must remain unapologetically, conscientiously and enthusiastically conservative in carrying out its responsibility to assure continuing improvement in health care and to assure that the direction in which we move is, in fact, the direction of progress rather than disaster.

We thank God for our well-intentioned liberal friends with all of their Utopian fantasies, but we beg God to help save us from some of their unholy schemes.

Teaching Case

Mountaineer's choice

Mr. Chandler was one of my first cancer patients, admitted innocently enough with "pneumonia." But, when the pneumonia cleared, the fearful shadow in his chest X-ray appeared. Then the fervor born in my first subinternship and carried over into practice came to the fore and I went to the patient with a forthright statement of the "facts," ready to go all out in diagnosis and treatment. I told of the need for a tissue diagnosis, how that would be done, and the treatment options to follow. He gazed at me silently, seemingly unmoved until I finished by offering him a referral for a biopsy. Then, he simply and quietly said, "No, I'll just go back to the farm for awhile."

He had been the oldest of eight children, raised in the lumber camps of the West Virginia Appalachians. He applied himself in the schools of the day and excelled in arithmetic. In church, he took in the doctrines of a just but fearsome God. He became an engineer on the Shay logging locomotives, and then a coal miner. In addition to God, he picked up two more "men in his life" (his son's expression) -- F.D.R. and John L. Lewis.

When he married, his wife's grandmother said, "Let him be the boss as long as he acts like he has some sense." And he was "the boss" to wife and family, but was kind and fair and helpful.

They lived on a farm where he loved to hunt and fish and there made his peace with nature. Oil changed was not dumped on the ground; waste was buried; even a cigarette butt carelessly thrown by a guest would be picked up. He killed game only to use, but otherwise lived and let live. A bear once came and ate the dog's food and went away unmolested. Skunks lived in peace under the front porch. But the family prospered to a degree -- never hungry, owing no one, owning their land.

So, he and his wife returned to that beautiful farm and resumed their lives as best they could. He climbed the hills and looked out across the valleys and drank in the majesty of what his eyes beheld. At dusk, they watched deer standing in a meadow who returned their gaze with inquisitive alertness. They went to the trout stream, "so quiet and clear and pretty," and walked the woods together and "just sat on a log," talking of the joys and sorrows of their 50 years together.

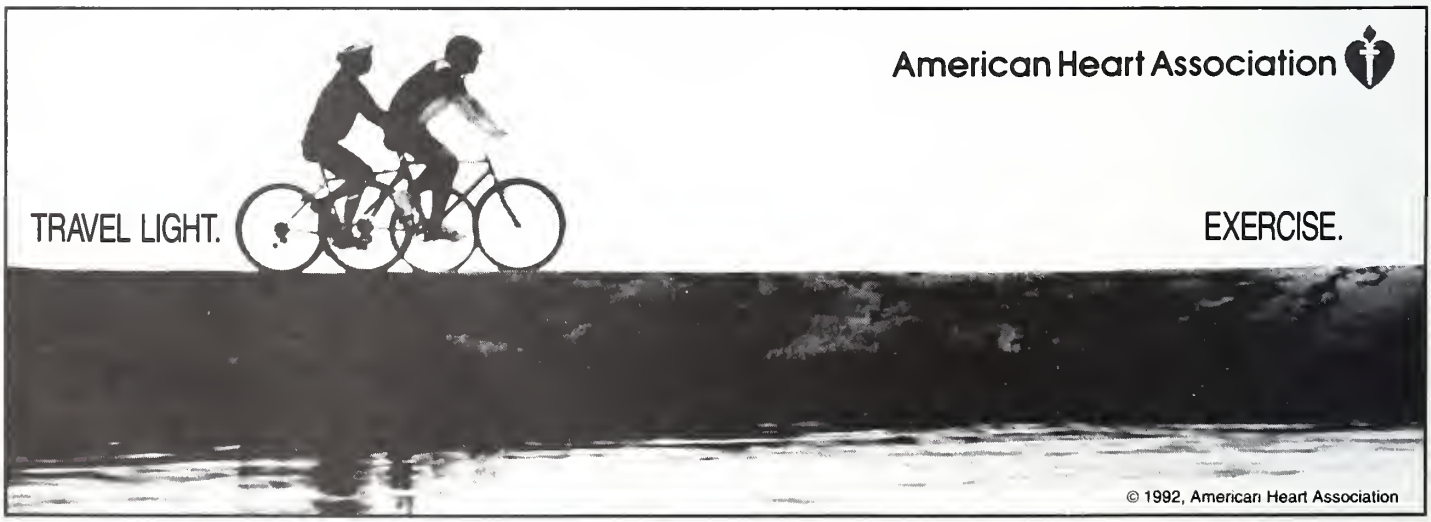
He rekindled old friendships, especially with those who shared his sense of humor. Part of the amusement was derived from me when he passed the life expectancy I had estimated for him.

He talked of death, but never morbidly or in self pity, never "why me?", or "maybe this is my last day." He told his wife to remarry (she didn't); he told his son to help his mother in every way that he could (he has). He feared God and yet had faith that He would be just.

Eventually, he had to move to town where his son could give more help. He never weakened in his resolve not to go through what he considered meaningless treatment. Even when he vomited blood, he declined to go to the hospital; he was still "the boss" -- the good husband and father whose wishes were to be honored. They alone took care of him.

I made one house call and declared his jaundiced body dead. His spirit has lived with me since.

Hugh A. Lindsay, M.D., Ph.D.
Morgantown



American Medical Association
Physicians dedicated to the health of America

For Your Benefit

AMA poised to respond to reform plan

The AMA is prepared to respond and communicate to the public, Congress and physicians once Clinton unveils his health system reform package.

AMA leaders will give Association members and patients immediate feedback and analysis of the proposal. The feedback will help them determine if the plan meets medicine's needs.

AMA strategy includes nationwide communications to physicians through an all-physician mailing that will reach the 718,000 physicians and medical students soon after the unveiling.

Also, a broad-based communications program will be executed to give the media and public AMA reaction and views on elements of the proposal. A grassroots strategy is planned for physicians and physician leaders to communicate with Congress.

American Medical Television (on CNBC) will outline the plan's impact on physicians and give physician response.

AMA publications will also compare its elements to those in the Association's own plan, Health Access America.

AMA triumphs, HCFA consultation policy reversed

Substantial AMA efforts helped reverse HCFA policies prohibiting primary care physicians from billing for pre- and postoperative consultations.

Effective June 28, the new policy eliminates distinctions between primary care physicians and specialists. It instructs carriers to use the current CPT definition of consultation in determining payments.

A letter from AMA EVP James S. Todd, MD, to HCFA said, "This policy is wrong and must be corrected."

"Current clinical practice includes numerous circumstances in which the surgeon's request to the patient's primary care physician for a pre-operative medical clearance or history and physical constitutes a request for a consultation," Dr. Todd wrote.

Prepared by the Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

At Annual Meeting

Scientific Session to focus on how "Doctors View Today's Dysfunctional American Family"

Aukerman

Comerci

Kelly

Morgan

Thase

Five physicians will be presenting lectures for the Scientific Session entitled *"Doctors View Today's Dysfunctional American Family,"* which will be conducted on Thursday, August 19 at 8 a.m. during the WVSMA's Annual Meeting at The Greenbrier.

Participating in this session will be **Glen Aukerman, M.D.**, professor and chair of the Department of Family Medicine at West Virginia University; **George Comerci, M.D., F.A.A.P.**, director of pediatric and adolescent medicine at the Desert Hills Center for Youth and Families in Tucson, Ariz.; **Michael A. "Tony" Kelly, M.D., F.A.C.E.P.**, director of the Emergency Departments at Beckley and Welch General Hospitals; **David Z. Morgan, M.D., F.A.C.P.**, professor of medicine at West Virginia University; and Michael E. Thase, M.D., an associate professor of psychiatry at the University of Pittsburgh.

Biographical information about these panelists begins below and additional information about this year's WVSMA Annual Meeting can be obtained by phoning Nancie Divvens at (304) 925-0342. A registration form for the meeting appears on page 294 in this issue.

Speakers profiled

Dr. Aukerman received his medical degree from the Ohio State University College of Medicine in Columbus and then completed a residency in family medicine and a sub-residency in pediatrics at Miami Valley Hospital in Dayton, Ohio.

From 1966 to 1992, Dr. Aukerman was in private practice in Jackson Center, Ohio. For much of this time, Dr. Aukerman served as a clinical assistant professor at the Ohio State University College of Medicine in Columbus.

In 1992, Dr. Aukerman joined the faculty of the Department of Family Medicine at the University of Tennessee in Memphis. While teaching at UT, Dr. Aukerman was also scholar-in-residence from January 1992 to November 1992 at the Bureau of Health Professions for the Health Resources and Services Administration in Rockville, Md., where he then worked for seven months as chief medical officer of the National Practitioner Data Bank.

In May of this year, Dr. Aukerman accepted his current position at West Virginia University as professor and chair of the Department of Family Medicine. Currently serving as a member of the White House Health Reform Task Force, Dr. Aukerman is also serving on the speakers panel for this national group.

A past president of the American Academy of Family Physicians, Dr. Aukerman is also active in the West Virginia and Ohio chapters of this organization. In addition, he is a member of the AMA, the American College of Physician Executives, the American College of Preventive Medicine, the WVSMA and the Ohio State Medical Association.

In June 1991, Dr. Aukerman had his article, *"Access to Health Care for the Uninsured: The Perspective of the American Family Physicians,"* published in JAMA. A noted lecturer, Dr. Aukerman has spoken extensively at medical meetings in the United States, as well as in Canada, Saudia Arabia and Puerto Rico.

Dr. Comerci, who will also be delivering the Edmund B. Flink Address at the WVSMA's Annual Meeting, received a pharmacy degree from Rutgers University and then obtained his medical degree from Temple University Medical School in 1959. He interned with the Public Health Service and completed his residency at Saint Christopher's in Philadelphia.

Following his residency, Dr. Comerci went into private practice in New Jersey for four years and then left the state when he was appointed director of the Outpatient Department at Glennon Hospital at St. Louis University Medical School. In 1969, he relocated to Tucson, Ariz., to become the director of ambulatory pediatrics and deputy head of the Department of Pediatrics at the University of Arizona. Dr. Comerci spent more than 20 years as a full-time faculty member at the university, serving also as the first associate dean for continuing medical education and as a professor of pediatrics.

In 1991, Dr. Comerci assumed his present post as director of pediatric and adolescent medicine at the Desert Hills Center for Youth and Families in Tucson. During his years in the Tucson medical community, Dr. Comerci has also served as medical director of the Adolescent Medicine Inpatient Unit at Tucson Medical Center; as medical director for Tucson's Center for Youth Development and Achievement; and as medical director for the Tucson Job Corps.

Recently elected vice-president elect of the American Academy of Pediatrics, Dr. Comerci is a former president of the Ambulatory Pediatric Society, the Arizona Pediatric Society and the Pima County Pediatric Society. He is board certified by the American Board of Pediatrics and is a fellow of the Society for Adolescent Medicine. Dr. Comerci is the uncle of WVSMA President-Elect James L. Comerci, M.D.

Dr. Kelly is a native of Canada who received a B.S. degree in mathematics in 1977 and his medical degree in 1981

from Dalhousie University in Nova Scotia, where he also completed a rotating internship.

From 1982-83, Dr. Kelly worked in Hiawassee, Ga., as a general practice and emergency room physician. He then relocated to Beckley to serve as director of the Department of Emergency Medicine at Beckley Appalachian Regional Hospital for four years.

Since 1985, Dr. Kelly has been managing his own company, Kelly Medical Corporation, and contracted with hospitals and urgent care centers throughout southern West Virginia to staff their facilities and provide consultative work in the field of outpatient ambulatory medicine. His company now employs 45 physicians and he is the director of emergency services at Beckley Hospital and Welch Emergency Hospital. In addition, since 1986 Dr. Kelly has been affiliated with the Charleston Area Medical Center, both Memorial and General Divisions, as a clinical instructor.

A diplomate of the American Board of Emergency Medicine, Dr. Kelly is also a fellow of the American College of Emergency Physicians. Besides running Kelly Medical Corporation, Dr. Kelly recently formed a new company, Medical Services, Inc., which is a multi-specialty billing corporation.

Dr. Morgan joined the U.S. Navy in 1942 after graduating from Kingwood High School in Kingwood, W.Va. He served until 1945, achieving the rank of ensign, and then began his studies at West Virginia University. Dr. Morgan received a B.S. degree from WVU in medicine in 1950 and then obtained his M.D. degree from the Medical College of Virginia in 1952.

After interning at Ohio Valley General Hospital in Wheeling, Dr. Morgan returned to WVU to work as a member of the staff of Student Health Services. In 1955, he went into private practice in Morgantown, but closed his practice in 1961 to begin a residency in internal medicine at WVU.

Since 1961, Dr. Morgan has been affiliated with the WVU School of Medicine in many capacities including serving as an instructor, assistant dean, associate dean for student affairs, director of continuing medical education and as the associate dean of medical affairs. In July 1988, he established the Geriatric Program at WVU and served as its director until his recent appointment as a professor of medicine. Although Dr. Morgan no longer serves as director of the Geriatric Program, he continues to be involved with this program as a full-time faculty member and clinician, and also works as the medical director for three long-term care facilities in the Morgantown area.

A past president of both the WVSMA and the Monongalia County Medical Society, Dr. Morgan has served as a lobbyist to the West Virginia Legislature for the WVSMA and he is currently vice-chairman of the WVSMA Committee on Medical Education and is an associate editor of the *West Virginia Medical Journal*. An active member of the Morgantown community, Dr. Morgan is the founder of Community Living Initiatives Corporation, an organization targeting issues of concern to seniors, and he regularly volunteers at the Morgantown Health Right Clinic.

Besides his editorial work for the *West Virginia Medical Journal*, Dr. Morgan holds appointments to the Editorial Advisory Boards for *Postgraduate Medicine - Senior Patient* and *Geriatric Care and Rehabilitation*. He has authored a syndicated weekly newspaper column and a booklet entitled *"The Little Doctor Makes House Calls."*

Dr. Thase, who will also be speaking at the West Virginia Psychiatric Association's meeting during the WVSMA's Annual Meeting, received a B.A. degree in psychology from Wright State University in Dayton, Ohio, and obtained his medical degree from Ohio State University in Columbus in 1979. He completed an internship and general psychiatry residency at the University of Pittsburgh School of Medicine, Western Psychiatric Institute and Clinic in Pittsburgh.

From 1982-84, Dr. Thase studied clinical research on a postdoctoral fellowship at the University of Pittsburgh, Western Psychiatric Institute and Clinic, and then joined the faculty in 1983 as an assistant professor of psychiatry. In 1987, he was promoted to his current position as an associate professor of psychiatry, and the following year assumed his other present posts as medical and research director of the Mood Disorders Module at the university, as well as associate director of the Clinical Research Center.

In 1984, Dr. Thase received the Marie H. Elredge Award from the American Psychiatric Association. A noted author, his articles have been published extensively in a variety of journals and this year he co-authored a book entitled, *"Cognitive Therapy with Inpatients: Developing a Cognitive Milieu."*

ACPE offers awards

The American College of Physician Executives is again seeking entrants for its National Awards Program who believe they may have demonstrated a way to improve the quality of care or manage health care costs.

Entry deadline is August 31 and forms are available from the ACPE by calling (800) 562-8088.

Research Day Winners

The winners of the annual Research Day competition sponsored by the Charleston Area Medical Center and the Charleston Division of the Robert C. Byrd Health Sciences Center are (from left to right) Iyad M. Zeid, M.D.; Debra Stultz St. Clair, M.D.; John V. Onestinghel, M.D.; Daniel L. Stickler II, MSIV; James B. Luther, psychology intern; and Michael P. Smith-O'Brien, M.D.

CCFA begins program to help ulcerative colitis sufferers

An initiative designed to heighten research and education in the field of ulcerative colitis (UC), to improve patients' quality of life, and to produce the first nationwide prognostic and quality-of-life databases has been introduced by the Crohn's and Colitis Foundation of America (CCFA) and Kabi Pharmacia Inc.

Called the "Partnership for Quality Living," this program unites patients, physicians, nurses, industry, and the non-profit sector in an effort to improve the quality of life for UC patients. The partnership will have participating gastroenterologists, or their nurses, complete forms on various patients, outlining their conditions and courses of therapy. Patients will then complete forms describing their treatment and quality of life. This information will be centrally computerized and analyzed over time to create a population-based body of data designed to offer new insights into prognostic indicators, quality of life, and future research efforts.

In addition, patients will also assist by submitting participation tracking forms to their pharmacist whenever they fill a prescription. These forms will help provide insight into the outcomes associated with various patient profiles and courses of treatment. Patients will also receive regular mailings of educational materials to help them cope with their disease.

For more information on the program, phone (800) 492-4321.

New organization formed to assist physician inventors

The American College of Physician Inventors was recently incorporated to establish a forum for creative professionals and to assist in the inventing, patenting and marketing process of ideas applicable to the medical profession. The ACPI also acts as a liaison between physician inventors, the medical community, industry and regulatory agencies.

For further information, contact Frank Debernardis at 352 Hillcrest Road, Ridgewood, N.J. 07450, (201)-447-6926.

Financial assistance available for leukemia patients

The Leukemia Society of America's Patient Aid Program provides supplementary financial assistance to patients with leukemia, the lymphomas, multiple myeloma and Hodgkin's disease, as well as referral services to other sources of help in the community.

Supported entirely by public contributions, the Patient Aid Program is administered through the Western Pennsylvania Chapter. Funds can be used towards drugs used in treatment of leukemia and allied diseases, the processing, typing and screening of blood components, transportation to doctors' offices and some X-ray therapy.

For further information, contact the Western Pennsylvania Chapter at (800) 726-2873.

Cerenex sponsors two ASCO honors

Cerenex Pharmaceuticals, a division of Glaxo Inc., will sponsor the American Society of Clinical Oncology's (ASCO) Young Investigator Awards and Clinical Research Development Award through 1995.

The Young Investigator Awards provide grants to promising young investigators to stimulate and encourage quality research in basic and applied oncology. The award recipients must be physicians (M.D. or D.O.) who are either in their final year of training in an oncology subspecialty postgraduate program or who have completed fellowship training within the past year, and are planning an investigative career in clinical oncology.

In addition, Cerenex is also supporting a Clinical Research Development Award to the investigator who is a relatively new member of a clinical faculty with the support and time needed to establish an independent clinical cancer research program that will be competitive for national funding.

Individuals interested in receiving more information and application forms may contact ASCO at (312) 644-0828, or write to: Award Selection Committee, American Society of Clinical Oncology, 435 North Michigan Avenue, Suite 1717, Chicago, IL 60611-4067.

NIH asthma treatment guidelines not being utilized in patient care

A survey of more than 4,000 asthma patients conducted by Mark Clements Research, Inc. reveals that the guidelines for the treatment of asthma recommended by the National Institutes of Health (NIH) two years ago have not yet reached the patient level.

The most significant findings are that the majority of survey respondents are using a beta-agonist on a regular basis, rather than on an as-needed basis, as recommended by the treatment guidelines. In addition, many respondents are not using, or are not using enough anti-inflammatory medications, which the NIH suggests should be the mainstay of maintenance therapy. More than 50 percent of survey participants are prescribed beta-agonists on a regular basis for symptom relief only, despite recent recommendations from the NIH about the over-reliance on these medications.

"It is worrisome that such a high percentage of asthma patients are prescribed beta-agonists for regular use without anti-inflammatory therapy," says Dr. James Keep, clinical professor at the University of California School of Medicine at San Diego. "Beta-agonists have a place as rescue medication to relieve asthma symptoms, however, if patients require increased, or regular, use of beta-agonists to relieve symptoms, they should discuss with their doctor initiating, or increasing, maintenance anti-inflammatory therapy. Anti-inflammatory therapy can help prevent symptoms and, if patients experience fewer symptoms, it is likely they'll need their inhaled beta-agonist less often."

In addition, the survey showed that patients are not using enough anti-inflammatory medications — either because their doctor has declined to prescribe anti-inflammatory medications or because so many patients (38%) fail to comply with the medication schedule prescribed by their doctor.

PHYSICIAN'S RECOGNITION AWARDS

We wish to congratulate the following WVSMA members who recently received Physician's Recognition Awards from the AMA for voluntarily completing 150 credit hours of continuing medical education during the past three years:

Cabell
David S. Clark, M.D.
Rafael E. Molina, M.D.
Maurice A. Mufson, M.D.
Larry D. Smith, M.D.
Marc Anthony Subik, M.D.

Central
Hao Chang, M.D.
W. Douglas Given, M.D.

Eastern Panhandle
D. Ewell Hendricks, M.D.
Edward P. Quarantillo, Jr., M.D.
Ophas Vongxiaburana, M.D.

Fayette
Miraflor G. Khorshad, M.D.

Harrison
Roberto A. Cunanan, M.D.
Ashgar Farsaii, M.D.
Carl R. Fischer, III, M.D.
Frederick A. Spencer, Jr., M.D.

Kanawha
Mark B. Ayoubi, M.D.
Clinton A. Briley, M.D.
Echols A. Hansbarger, Jr., M.D.
William L. Harris, M.D.
John M. Holbert, M.D.
Lester Labus, M.D.
Lee L. Neilan, M.D.
Gina Michelle Puzzouli, M.D.
Ujjal S. Sandhu, M.D.
Luis E. Soriano Ulloa, M.D.
Adla Adi, M.D.

Marion
Deloris I. Kline, M.D.
Stanard L. Swihart, M.D.

McDowell
Muthusamy Kuppusami, M.D.

Mercer
R. Arthur Gindin, M.D.

Monongalia
Mack Ira McClain, M.D.
Alan A. Rosenbloom, M.D.

Ohio
James L. Comerci, M.D.
Michael A. Fortunato, M.D.
Hossein Yassini-Fard, M.D.

Parkersburg Academy
Richard E. Johns, M.D.
Michael S. McIntosh, M.D.
Adam Toppercer, M.D.
Richard A. Yocum, M.D.

Preston
Darryl L. Landis, M.D.

Raleigh
Mousa I. Dababnah, M.D.
Iligino F. Salon, M.D.

Residents
Carole M. Dentino, M.D.

Summers
Jack D. Woodrum, M.D.

The West Virginia State Medical Association's

1993 Annual Meeting

August 18-21, 1993

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up Now!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

For more details about other area hotels/motels, contact the WVSMA at 304-925-0342. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1993 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code _____

Specialty _____

Payment by: Check Visa MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	____
	non-member	$175	____
Additional:			
Thursday, Aug. 19 Lunch and Learn (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
Friday, Aug. 20 WESPAC Luncheon (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
		TOTAL:	____

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

WESPAC

Lunch & Learn

Visiting state presidents from Pennsylvania, Maryland, Ohio, Indiana and Virginia, as well as Dr. Joseph Painter, president of the AMA, will be participating in a question and answer session on how POLITICAL ACTION COMMITTEES affect the legislative process.

What is a PAC's role in the legislative process?
How do other state PACs select their candidates to endorse?
What is the PAC's role within the medical society?
What is the future of PACs on a national and state level?

August 20, 1993 at Noon
During the WVSMA Annual Meeting
at The Greenbrier

The WVSMA has applied for CME credits. The cost for the luncheon is $25 and all physicians and auxilians are invited. If you would like to attend, send in the registration form and your check made payable to the WVSMA, P.O. Box 4106, Charleston, WV 25364.

IF YOU'RE INTERESTED IN POLITICS AND ARE CONCERNED WITH THE FUTURE OF HEALTH CARE - -
DON'T MISS THIS MEETING!

WESPAC Lunch & Learn

Name _____

Address _____

Phone _____

_____ Physician _____ Auxilian _____ No. Attending

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

West Virginia State Medical Association - Charleston

Aug. 7 - First Generation Loss Control Seminar, Clarksburg

Aug. 18-21 - WVSMA's 126th Annual Meeting, White Sulphur Springs

Robert C. Byrd Health Sciences Center - Morgantown

Aug. 6-7 - "Fourth Annual Surgeon General's Follow-up Conference for Children With Special Needs" (sponsored by the W. G. Klingberg Center for Child Development, Dept. of Pediatrics, WVU School of Medicine; and the West Virginia Handicapped Children's Services Program), Canaan Valley State Park, Davis

Aug. 29-Sept. 2 - "Oxygen Radicals and Lung Injury," (sponsored by WVU Dept. of Pathology and NIOSH), Lakeview Resort and Conference Center, Morgantown

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center, WVU, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Fairmont ★ Fairmont Clinic, July 21, 1 p.m., "Tobacco Cessation," Penny Glover, M.D.

★ Fairmont General Hospital, Aug. 3, 7:30 p.m., "New Antibiotics," Mary Castiglia, Pharm.D.

Logan ☐ Logan General Hospital, July 16, noon, "Treatment of Lung Carcinoma in the 1990s," Abdallah Alameddine, M.D.

Madison ☐ Boone Memorial Hospital, Aug. 10, 6:30 p.m., "Pediatric Surgical Emergencies," Eduardo Suson, M.D.

Man ☐ Man Appalachian Regional Hospital, July 20, 7 p.m., "New Directions in Asthma," Chandra Kumar, M.D.

☐ Man Appalachian Regional Hospital, Aug. 17, 7 p.m., "Domestic Violence," Ralph Smith, M.D.

Montgomery ☐ Montgomery General Hospital, Aug. 4, 12:15 p.m., TBA*

Point Pleasant ☐ Pleasant Valley Hospital, July 22, noon, "Breast Cancer," Arvind Kamthan, M.D.

☐ Pleasant Valley Hospital, Aug. 26, noon, "New Skin Conditioning Programs in Peels," Alfonso Amores, M.D.

Ripley ☐ Jackson General Hospital, July 9, 12:15 p.m., "Reconstruction of Oral Cavity with Implants," David Yates, D.M.D.

☐ Jackson General Hospital, Aug. 13, 12:15 p.m., "Pediatric Transport Concepts," TBA*

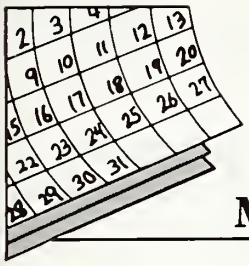
Princeton ☐ Princeton Community Hospital, July 19, noon, "Oncology Emergencies," Steven Jubelirer, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, July 26, 4 p.m., "Syncope," John Brick, M.D.

**To be announced*

"UNLESS YOU GAVE BIRTH TO AN ELEVEN POUND BABY GIRL .... I'VE GOT THE WRONG CHART."

Until there's a cure, there's the American Diabetes Association.



Medical Meetings

July

13-17–International Conference on Autism (sponsored by the Autism Society Canada and the Autism Society America), Toronto
15-17–National Health Reform: Making Health a Community Affair (sponsored by the American Health Planning Association), Washington, D.C.
17-18–First National Conference on Consumer Health Informatics (sponsored by the National Wellness Institute), Stevens Point, Wis.
21-25–15th National Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum (sponsored by The George Washington University Medical Center), Houston
25-30–Physicians and Their Families Workshop: Balancing Commitments to Family and Profession (sponsored by The Menninger Clinic), Crested Butte, Colo.
27-Aug. 1–55th Annual Meeting of the International College of Surgeons - United States Section, Seattle
31-Aug. 2–Urology Update (sponsored by Ohio State University), Kings Island, Ohio

August

8-11–Midwest Surgical Association, Lincolnshire, Ill.
11-15–Advanced Seminars in Dermatology (sponsored by the University of California Dept. of Dermatology), Newport Beach, Calif.
18-21–WVSMA's 126th Annual Meeting, White Sulphur Springs
21-25–American Association of Tissue Banks, Boston

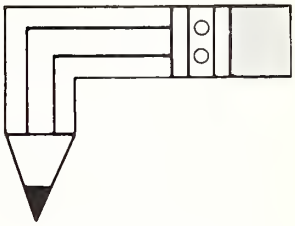
September

5-9–62nd European Atherosclerosis Society Congress, Jerusalem, Israel
7-12–American Academy of Neurological and Orthopaedic Surgeons, Las Vegas, Nev.
9-11–American Gynecological and Obstetrical Society, LaCosta and Carlsbad, Calif.
10-11–Where are the Donors? Strategies for Expansion of the American Donor Pool (sponsored by the American Association of Blood Banks), Arlington, Va.
11-14–The Decade of the Brain: An International Conference (sponsored by The George Washington University Medical Center), Washington, D.C.
18-20–7th Annual Brachytherapy Symposium: Focus on High Dose Rate Brachytherapy and Intraoperative Radiation Therapy (sponsored by Ohio State University), Columbus

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Sadness Between Creation and Creator

Sadness, oh you lingering thought for many years
Whenever the mind recalls
With the death of a creation -- an infant son
You are the product of the THIEF in the night.

Sadness, oh you strong emotion in distant past
A faint memory in recent years
You came with the death of a creator -- a Father
You are again an erupting volcano.

Sadness, you were put to rest again
But you came back to me
With the death of a creator -- a Mother
And I pray that in time, everything will fall into memory.

Sadness, oh you are forever a part of life
To remember and feel when loved ones depart
Farewell, my beloved three: the creation and creators
I the father and son together though apart

Rano Solidum Bofill, M.D.

Editor's Note: Dr. Bofill is the editor of the newsletter *Philippine Physician* and he wrote this poem after the recent death of his mother.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Special Note

If you are interested in becoming a member of the American Physicians Poetry Association and receiving their quarterly newsletter, send $25 ($15 for medical students) to William J. Wortman, M.D., 2711 Randolph Road, Suite 309, Charlotte, N.C. 28207.

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Expanded definition increases number of reported AIDS cases

The expanded case definition of AIDS has resulted in a significant increase in the number of reported AIDS cases in West Virginia. Statistics from the West Virginia AIDS Program indicate that from January 1 through the end of May 1993, there were 40 new AIDS cases reported in the state. Only 19 of these cases would have met the previous case definition, and 21 of these cases were identified as a result of the 1993 expanded AIDS case definition.

The 1993 expanded AIDS surveillance case definition includes all HIV-positive individuals who have fewer than 200 CD_4T-lymphocytes/µL or a CD_4 percentage of less than 14. In addition to the 23 clinical conditions included in the 1987 surveillance case definition, the expanded definition includes the addition of three clinical conditions: pulmonary tuberculosis, invasive cervical cancer, and recurrent pneumonia. Laboratory confirmation of HIV infection is required under the expanded definition.

The number of HIV-infected individuals with CD_4 counts less than 200 is substantially larger than the number of people with AIDS-defining clinical conditions. Therefore, the Centers for Disease Control and Prevention states that this new surveillance definition and the revised classification system for HIV infection will more accurately reflect the number of people with severely HIV-related immunosuppression and simplify the process of reporting cases.

If you have any questions about HIV/AIDS surveillance and reporting, contact Loretta Haddy or Joyce Zinn at the West Virginia AIDS Program at 1-800-423-1271.

Two WV hospitals recognized by national breastfeeding program

Charleston Area Medical Center's Women and Children's Hospital in Charleston and Grant Memorial Hospital in Petersburg have been nationally recognized for developing policies and practices to encourage and support new mothers who choose to breastfeed their babies. These two hospitals have each received a certificate of intent to support the Baby Friendly Hospital Initiative, a voluntary global program sponsored by the World Health Organization and the United Nations Children's Fund (UNICEF).

The purpose of this initiative is to assist and encourage hospitals in giving breastfeeding mothers the information, confidence and skills needed to successfully begin and continue breastfeeding their babies. Health experts consider breastfeeding to be the optimal way of providing ideal food for the healthy growth and development of infants.

Women and Children's and Grant Memorial are among the first 82 hospitals in the U.S. to receive these certificates of intent. The hospitals will now undergo a review process before the final Baby Friendly Initiative designations can be made. These two facilities are being recognized for their demonstrated commitment to support the practice of breastfeeding and to adopt the 10 steps UNICEF developed to support a woman's choice to breastfeed. Staff will receive training and assistance in implementing these steps which include patient education and information to help women choose to breastfeed, as well as practices which encourage breastfeeding and the formation and referral of breastfeeding support groups.

A national health goal for the year 2000 is that at least three out of four mothers breastfeed their infants. This national goal is more important than ever since increased rates of breastfeeding could result in significant savings in health care dollars.

Spina bifida camp offers many activities

Each summer since 1984, the Mountaineer Spina Bifida Camp has been a place for physically-challenged young people to take part, often for the first time, in such events as swimming, boating, fishing, dancing and other activities adapted for their special needs. They can also take a hayride or compete in wheelchair olympics, or they can take classes in arts and crafts, cooking or music. Most importantly, they learn about self-esteem and independence.

This camp is one of four of its kind in the nation. This year, 45 campers between the ages of 8 and 18 converged on the campsite at Cedar Lakes in Ripley from June 13-19. The campers came from 17 counties around the state.

Physicians wanting to provide their patients with more information about the camp can call Pat Kent of Handicapped Children's Services at 558-3071.

Rule bill will strengthen medical waste program

Passage by the Legislature of the Omnibus Rule Bill will make the Infectious Medical Waste Rule 64 CSR 56 permanent. This will allow the use of more program time in the field, and it is hoped this will enable the staff of the Office of Environmental Health Services to identify more problem areas and promptly resolve them.

The Infectious Medical Waste Program is especially concerned about some areas of West Virginia being underserved or some facilities receiving inadequate service by haulers. Generators are encouraged to report any difficulties they encounter with their haulers or any facet of their program to Joe Wyatt at 1-800-922-1255.

The WVSMA & Conomikes Associates, Inc.

Present

MANAGED CARE

How to deal with it properly

- How to avoid HMO/PPO contracting traps
- Capitation vs. Fee-for-Service
- How to get paid what you deserve

Charleston - September 28 Charleston Area Medical Center
3110 MacCorkle Avenue
9 a.m. to 4 p.m. (Lunch provided)

Registration Form

MANAGED CARE: How to deal with it Profitably

Enrollee Name _____

Physician's Name _____

Address _____

City _____

State _____ Zip _____ Phone _____

WVSMA member ($195) _____ Non-member ($225) ____
2 or more ($175) _____ 2 or more ($200) _____

Payment by: Check ___ Visa ___ Mastercard ___

Card Number _____

Expiration Date _____

Signature _____

Registration Fees:

$195 per person (Members/Member's Office staff)
Two or more persons from the same practice $195 for the first enrollee and $175 for each additional enrollee

$225 per person (Nonmembers/Office Staff)
Two or more persons from the same practice $225 for the first enrollee and $200 for each additional enrollee

NOTE: To register more than one person, copy and complete information on a separate sheet.

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown.

Wimmer named distinguished teacher

Mary J. Wimmer, Ph.D., associate professor of biochemistry, has been awarded the 1993 Distinguished Teacher Award by the School of Medicine.

Dr. Wimmer has been a faculty member of the School of Medicine since 1978. She teaches basic biomedical sciences, lectures in advanced biochemistry and acts as an advisor to second, third and fourth-year students. The selection committee noted Dr. Wimmer's careful and organized approach to teaching and her uniformly high ratings on student evaluations.

In addition to teaching, Dr. Wimmer conducts research for the USDA Forest Service on the effects of pesticides on the environment. She has involved a number of WVU undergraduate students in this work over the past several years, and four of these students will be admitted to the School of Medicine next year.

Surgery faculty, residents participate in WVACS meeting

Several Department of Surgery faculty members and residents recently participated in the spring meeting of the West Virginia Chapter of the American College of Surgeons (WVACS) in White Sulphur Springs.

At the meeting, Dr. Robert Gustafson, associate professor, completed his term as a WVACS councilor; and Dr. Gregory Timberlake, associate professor, was elected to a three-year term as a councilor. In addition, Dr. Geoffrey Graeber, professor, Dr. Ronald Hill, associate professor, and Dr. Richard Vaughan, assistant professor, lectured at the meeting; and Drs. Steven Bossinger and Rebecca Price, residents, presented papers.

Also during the conference, Dr. Gene Duremdes, chief resident, received second place in the resident competition for his paper "Intra-Abdominal Hypertension in the Trauma Patient."

Ducatman receives Hilker award

Ducatman

Dr. Alan Ducatman, director of the Institute of Occupational and Environmental Health, has won the Central States Occupational Medical Association's Robert R. J. Hilker award.

Dr. Ducatman's award was presented at CSOMA's annual meeting in Chicago where he delivered an award lecture entitled "Occupational Health and Environmental Medicine -- Comparisons, Not Contacts."

Pulmonary, critical care physicians attend ATS/ALA conference

Several physicians in the Department of Medicine, Section of Pulmonary and Critical Care, attended the 1993 Conference of the American Thoracic Society/American Lung Association from May 16-19 in San Francisco.

The following physicians presented papers at the conference: Dr. N. LeRoy Lapp, professor; Dr. Susan Weber, instructor; Dr. Jeff Wilt, fellow; and Dr. Harakh Dedhia, associate professor. Dr. Daniel Banks, professor, co-authored one of the papers presented.

During the conference, Dr. Wilt was named the 1992-93 Outstanding Fellow in the Department of Medicine.

Neurologists complete national exam

Several WVU neurologists recently participated in the oral examination of the American Board of Psychiatry and Neurology in San Diego

The neurologists undergoing the exam were Drs. John Bodensteiner, Lenore Breen, Robert Keefover, Bill Cutlip, Laurie Gutmann, James Martin and Ludwig Gutmann.

Riggs named vice chair of neurology

Dr. Jack Riggs, professor of neurology, has been appointed vice chair of the Department of Neurology.

Dr. Riggs has been a member of the department since 1981. He holds joint academic appointments in the departments of community medicine and internal medicine, and has a special interest in the epidemiology of neurological diseases, aging and neuromuscular disorders.

Pediatrics recognizes faculty, residents at achievement banquet

Several faculty members and residents in the Department of Pediatrics were recognized at the department's achievement banquet May 21 at the WVU Erickson Alumni Center.

The individuals honored included:

- Dr. Larry Rhodes, assistant professor, Outstanding Teacher Award;
- Dr. Lisa Fazi, resident, Resident Teaching Award;
- Dr. Linda Nield, resident, Outstanding Resident in Ambulatory Medicine Award;
- Dr. Lee Pyles, assistant professor, Pediatric Research Award;
- Dr. Hatim Omar, resident, Resident Research Award; and
- Dr. Tim Hoffman, resident, Outstanding Intern Award.

Retirees honored

The School of Medicine recently held a reception to honor three retiring faculty members.

The honorees included Roy Butcher, Ph.D., professor of obstetrics/gynecology; Gale Rafter, Ph.D., professor of biochemistry; and Nathaniel Rodman, M.D., professor of pathology.

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Lee Bldg. Suite 102 · 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH
EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD

Specializing in
Head and Neck Cancer Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

- **35-bed JCAHO Accredited Hospital**
- **Ambulatory Care/ Same Day Surgery**

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

Marshall ranks fifth in nation in number of primary care grads

According to a study performed by the Association of American Medical Colleges, Marshall ranked fifth in the United States in the percentage of graduates entering primary care practice.

Other recent statistics have shown Marshall had the second highest percentage nationally of graduates entering family practice in 1990, and also ranked the third-highest for the three-year period from 1990 to 1992. The AAMC's broader measure, based on 1987 graduates who had actually entered practice, also encompasses general internal medicine and general pediatrics.

"This study clearly demonstrates that Marshall is turning out the kind of doctors this country needs most -- generalist physicians," according to MU President J. Wade Gilley.

A previous AAMC study based on questionnaires completed by graduating seniors showed that 1991 Marshall graduates were more likely to practice in smaller and socioeconomically deprived areas that their counterparts at other North American schools.

The graduates were three times more likely to practice in towns with populations of 2,500 to 10,000, and nearly twice as likely to practice in non-suburban cities of 10,000 to 50,000 people. Among the Marshall graduates, 16.7 percent (compared to a national mean of 9.5 percent) planned to establish practices in rural areas considered to be socioeconomically deprived.

Dr. Robert B. Walker, chairman of Marshall's Department of Family and Community Health, said an informal survey of practicing medical graduates showed that one-fourth of them were in towns of fewer than 10,000 people.

New director of maternal and fetal medicine named

Perinatologist Howard R. Gordon, M.D., became director of maternal and fetal medicine at Marshall on June 7 through a collaborative effort with Valley Health Systems and Cabell Huntington Hospital.

Dr. Gordon has taught at Tripler Army Medical Center, the U.C.L.A. School of Medicine, the University of California-San Francisco School of Medicine and Charleston Area Medical Center. He received his undergraduate degree from Princeton University and his M.D. degree from the University of Rochester, where he also completed a fellowship in microbiology-genetics and his internship. Dr. Gordon completed his residency training at Columbia Presbyterian Medical Center, where he became chief resident.

A member of the board of directors of the West Virginia Perinatal Society, Dr. Gordon is treasurer for the West Virginia Perinatal Association and also provides obstetrics consultation to the Maternal and Child Health Medical Advisory Committee. His research interests include innovative approaches to clinic prenatal care, blood flow studies of fetuses in distress during labor, and management of premature rupture of membranes. His work has been published in the *New England Journal of Medicine*, the *American Journal of Obstetrics and Gynecology*, as well as other journals.

As director of maternal and fetal medicine at Marshall, Dr. Gordon's diagnostic tools will include the Ultramark 9 Ultrasound System with High Definition Imaging, regarded as the most advanced instrument of its kind. The unit, which will be located in Cabell Huntington's high-risk pregnancy section, produces photographic printouts so detailed that fetuses' hair often is visible.

The superb image quality of the Ultramark 9 results from a supercomputer integrated into the ultrasound system itself, a combination pioneered in this model. The unit provides superb spatial and contrast resolution for extraordinary detail of the fetal heart, brain, face, abdomen, spine and neural tube; offers a highly advanced measurement and analysis package which provides gynecological, fertility, and single and twin OB calculations; and offers exceptional pulsed and color Doppler sensitivity for evaluation of fetal well-being in high-risk cases.

Moat retires; Fenger named acting chair

Albert G. Moat, Ph.D., chairman of microbiology at Marshall since 1978, is retiring this summer. Terry W. Fenger, Ph.D., a professor of microbiology who joined the Marshall faculty in 1979, has been named acting chairman of the department.

"Dr. Moat played a significant role in the development and growth of both his department and the School of Medicine," Dr. Fenger noted. "During his years at Marshall, he has been administrative director of the multimillion dollar cell regulatory biology project funded by the National Science Foundation's EPSCoR program, has served on a variety of school and university committees, and has been a strong advocate for MU's biomedical sciences graduate program."

Dr. Moat co-authored the textbook "Microbial Physiology," which is central to graduate school programs nationwide. He has been active in the American Society for Microbiology, serving as president of the Allegheny Branch in 1986. In addition, Dr. Moat is an elected fellow of the American Academy of Microbiology and a diplomate of the American Board of Microbiology.

A native of Spring Valley, N. Y., Dr. Moat earned his B.S. and M.S. degrees from Cornell and his Ph.D. from the University of Minnesota. He has been working toward completion of a master's degree in counseling and rehabilitation at Marshall.

Where quality is affordable . . .

Participating Dealer For AMERINET, SUNHEALTH, and VHA ACCESS

BEAUTIFUL OFFICE SUITES in easy to visualize arrangements featuring styles in TRADITIONAL, CONTEMPORARY, PERIOD and more. Enjoy the beauty of CHERRY, OAK, MAHOGANY and WALNUT. You'll find them all on our showroom floors.

CUSTOM OFFICE FURNITURE, INC.

1260 GREENBRIER ST. CHARLESTON, WV 25311

INTERIOR DESIGN SERVICE
SPACE PLANNING

PHONE 343-0103 or 1-800-734-2045
WV CONTRACTOR NO. WV008652

THE WHEELING CLINIC

WHEELING, WEST VIRGINIA 26003

Wheeling, 234-2000 • St. Clairsville, (614) 695-2511 • New Martinsville area, 455-2222 • Wellsburg-Steubenville area, 737-3700
Martins Ferry area, (614) 633-4557 • toll-free no. out of state, 1-800-245-8015

INTERNAL MEDICINE

General
D. J. Panucci, M.D.
P. R. Hedges, M. D.
R. N. Lewis, M. D. (St. Clairsville)

Peripheral Vascular Disease
J. D. Holloway, M. D.

Cardiovascular
A. M. Valentine, M. D.
W. E. Noble, M. D.

Rheumatology
R. Vawter, M. D.

GENERAL SURGERY
E. C. Voss, M. D.
G. Galvin, M. D.
E. Cohen, M. D.

UROLOGY
D. C. Trapp, M. D.

OPHTHALMOLOGY
R. V. Pangilinan, M. D.
D. Simbra, M. D.
H. F. Leeper, M. D., Ph.D.
Kathryn M. Clark, O. D.

OTOLARYNGOLOGY/ MAXILLO-FACIAL SURGERY
W. A. Tiu, M. D.
A. G. Matadar, M. D.

RADIOLOGY
Valley Radiologists, Inc.

FAMILY PRACTICE
G. L. Cholak, M. D. (St. Clairsville)
E. L. Coffield, M. D. (New Martinsville)
C. P. Entress, M. D.
T. H. Korthals, M. D. (St. Clairsville)
J. H. Mahan, M. D. (St. Clairsville)

PODIATRY
B. Blank, D.P.M. (St. Clairsville)

DERMATOLOGY
G. A. Ganzer, M. D.

NEUROLOGY
H. L. Kettler, M. D.

BEHAVIORAL MEDICINE
S. D. Ward, M. D. (Martins Ferry)
D. P. Hill, M. D. (Martins Ferry)
R. Paolini, D. O. (Martins Ferry)

ANCILLARY SERVICES
Optical
Speech Therapy/Audiology
Counseling/Group Therapy
Biofeedback Laboratory
Electrology/Cosmetic Therapy
Electrocardiography
Electroencephalography
Neurological Studies (Non-invasive)
Roentgenology
24° A/EEG Scanning Service
Cardiac Ultrasound
Clinical Laboratory

AMA Annual Meeting a valuable experience

Dear Fellow Medical Students:

Myra and I bring you this message still filled with the excitement of attending the Annual Meeting of the American Medical Association - Medical Student Section in Chicago. We have many new plans to implement that we learned from officers of other chapters, and we in turn were able to provide them with a few new ideas.

The meeting opened on Thursday evening, June 10, with a workshop on chapter development and membership enhancement. This was followed by a welcoming reception where we had the opportunity to meet the delegates from other states.

Friday and Saturday were the true "business" days of the convention. On Friday, resolutions presented by the membership were reviewed in committee, and other members were given the opportunity to give testimony for or against them. These resolutions were then presented to the entire delegation on Saturday for a vote and the ones which were adopted were advanced to the AMA's House of Delegates for consideration. This stage of the process is very important because if a resolution is adopted by the AMA House of Delegates, it may then be passed on to the state and national delegates for consideration as new policy.

Some of the measures which were accepted included:

- A resolution that makes stalking a crime.
- A resolution encouraging medical education to include a program in pain management.
- A resolution that the AMA develop model state legislation to amend the Uniform Child Custody Act to place greater weight on the best interests of the child over biological linkage.
- A resolution that the AMA develop legislation making provisions for organ donation within a living will, and that physicians discuss advance directives and organ donation as part of the ongoing doctor-patient relationship.
- A resolution that the AMA encourage federal legislation that would ban smoking on passenger trains.
- A resolution that the AMA strongly recommend that all medical schools provide to medical students, as part of student fees, HBV vaccinations and subsequent antibody titres until immunity is acquired.

Saturday evening, our state delegation, which included the two of us as well as Kevin Kaufman, immediate-past MSS president, and Joseph Touma, president of the WVU-Charleston chapter, had the wonderful opportunity of meeting with the WVSMA delegates for a dinner meeting. This was followed by a WVSMA-MSS caucus where we made many exciting plans for projects for the coming year, including ways to increase participation in national meetings by members of the local chapters.

The highlight of the convention, though, was the address of Hillary Clinton to the opening session of the AMA House of Delegates. Those of us who stood in line for over one hour and then sat in folding chairs another hour waiting for the session to begin, soon forgot these inconveniences when we had the privilege of hearing Clinton outline the Health Care Reform Plan. Attendance at this meeting reaffirmed our belief in the importance of membership in the WVSMA and the AMA as our voice in the legislative and executive branches of government. It was clear from Clinton's address that the voice of AMA is being heard, and that she and the president realize that a plan that overlooks the will and interest of physicians will not be successful.

We left Chicago feeling refreshed with new ideas to strengthen our local chapters and our state organization. We are very appreciative to the WVSMA for their support in sending us to this meeting.

In August, we will be traveling to Columbus, Ohio, to meet with other state MSS leaders in our section, and we hope to gain even more ideas to bring back on how we may improve our chapters.

Mark S. Wright
WVSMA-MSS President

Myra Wilkerson
WVSMA-MSS Secretary-Treasurer

WILLIAM C MORGAN, Jr., M.D., F.A.C.S.
Otologist
Diplomate, American Board of Otolaryngology

OTOLOGY: DISEASES & SURGERY OF THE EAR

Sheri L. Jeffries
Audiologist

304-345-7100

Complete Audiological Services • Hearing Aid Dispensing & Service
Assistive Listening Devices • Electronystagmography • ABR

ST. FRANCIS MEDICAL PLAZA • 331 LAIDLEY STREET, SUITE 602 • CHARLESTON, WV 25301

Make your birthmarks disappear.

Certified By: American Board of Plastic Surgery
Fellow of the American College of Surgeons
Fellow of the Royal College of Surgeons (Canada)

Now there's a safer and more effective treatment for red vascular birthmarks

Fast . . . F.D.A. Approved . . . Near your hometown.

With our new Candela Vascular Lesion Laser, we can now treat birthmarks like Port Wine Stains and other red blemishes including small facial veins . . . effectively and with minimal discomfort.

- The latest in medical laser technology. This method has been approved by the F.D.A. and has been proven safe for children and infants.
- No surgery required.
- Treatments are done right in the office without a hospital stay.

Learn how you can make birthmarks disappear.
Call for a consultation appointment:

1-800-628-6748

LAWRENCE W. TARRANT, M.D.

ASSOCIATES IN OBSTETRICS AND GYNECOLOGY

OFFERING PERSONALIZED CARE 24 HOURS A DAY 7 DAYS A WEEK
FOR OBSTETRICAL & GYNECOLOGICAL EMERGENCIES & FOR INFANT DELIVERY

OUTPATIENT & OFFICE SURGERY

9 MEMBER GROUP OF OB-GYN SPECIALISTS

CHARLES W. MERRITT, M.D.
ROBERT P. PULLIAM, M.D.
OWEN C. MEADOWS, M.D.
MICHAEL T. WEBB, M.D.
ANGEL L. ROSAS, M.D.
NANCY R. WEBB, M.D.
NORMAN W. TAYLOR, M.D.
WILLIAM A. SCARING, M.D.
NORMAN L. SIEGEL, M.D.

- CONTRACEPTIVE COUNSELING
- ARTIFICIAL INSEMINATION
- UROLOGICAL EVALUATIONS & TREATMENT
- INFERTILITY EVALUATIONS
- BREAST SCREENING

255-1541

410 CARRIAGE DR. BECKLEY

Obituary

J. C. Huffman, M.D.

Dr. Jacob Camden Huffman, 80, of Buckhannon, who was president of the WVSMA from 1959-60, died May 27 in St. Joseph Hospital.

Born in Sutton, Dr. Huffman graduated from West Virginia University and then received his medical degree from the Medical College of Virginia in 1938, interning at Ohio Valley General Hospital in Wheeling. A family practitioner, he served in the U.S. Army from 1942-46 and then devoted himself to caring for patients in the Buckhannon community.

A very active member of the WVSMA, Dr. Huffman held many leadership roles in addition to his presidency during his career, including serving as chairman of the Interprofessional Relations Committee, chairman of Council, councilor-at-large and AMA alternate. In addition to his positions with the WVSMA, Dr. Huffman was a past president of the Central Medical Society and of the West Virginia Chapter of the American Academy of Family Physicians.

Dr. Huffman served on the Advisory Council of the West Virginia University School of Medicine and was inducted into the Order of Vandalia. He was a Paul Harris Fellow in Rotary International and was a former chairman of the Board of Trustees at the First Methodist Church of Buckhannon. In 1976, Dr. Huffman was named Citizen of the Year by the Buckhannon Chamber of Commerce.

Survivors include his daughter, Kay Huffman Goodwin of Ripley; son, Lt. Colonel Jacob C. Huffman Jr. of Ripley; brother, Dr. William Ward Huffman of Parkersburg; and three grandchildren.

The family suggests contributions be made to the West Virginia University School of Medicine, Morgantown, or to the Dr. J. C. Huffman Scholarship Fund, St. Joseph's Hospital, Buckhannon.

Society News

McDowell

The members voted unanimously to make $500 donations to the McDowell Public Library, the McDowell County Humane Association, and Mission Ministries.

In addition, the Medicaid Providers Tax was also discussed at this meeting, and Dr. Barnes mentioned the advisability of the society devoting more time and funds on preventitive medicine and health education efforts in the county.

New Members

We would like to welcome the following new members to the WVSMA:

Juan D'Brot, M.D.
P.O. Box 210
Montgomery, WV 25136

Darryl Landis, M.D.
106 N. Price Street
Kingwood, WV 26537

EATING RIGHT CAN HELP REDUCE THE RISK OF CANCER.

It can also help you reduce your weight.

And since a 12-year study shows that being 40% or more overweight puts you at high risk, it makes sense to follow these guidelines for healthy living! **Eat plenty of fruits and vegetables rich in vitamins A and C—oranges, cantaloupe, strawberries, peaches, apricots, broccoli, caulflower, brussel sprouts, cabbage. Eat a high-fiber, low-fat diet that includes whole-grain breads and cereals such as oatmeal, bran and wheat. Eat lean meats, fish, skinned poultry and low-fat dairy products. Drink alcoholic beverages only in moderation.**
For more information, call 1-800-ACS-2345.

AMERICAN CANCER SOCIETY®

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Special Article
WVSMA staff members highlighted 318

Special Reports
An overview of the AMA Annual Meeting 320
An overview of the HMSS Annual Meeting 321

Scientific Newsfront
Supraventricular tachycardia: Catheter ablation in 72 patients 324
Safety belt use and hospital charge differences among motor vehicle crash victims 328
Manuscript Guidelines 330
Chlamydia trachomatis genital infections
Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of West Virginia University 331

President's Page
Medical system failure? 336

Editorial
No reality except in action 337

Our Readers Speak
Carotid endarterectomy article needs clarification 338

In My Opinion
Difficult recovery from addiction made easier by support of my peers 340

Special Departments
General News 342
Annual Meeting Information 349-355
Continuing Medical Education 356
Medical Meetings/Poetry Corner 357
Bureau of Public Health News 358
Robert C. Byrd Health Sciences Center of WVU News 360
Marshall University School of Medicine News 362
Auxiliary News 364
Obituaries 366
Classified 369
August Advertisers 370

Front Cover

Three guests depart from The Greenbrier for a scenic horseback ride. Photo courtesy of *Stephen J. Shaluta Jr.,* West Virginia Division of Tourism and Parks.

WVSMA staff members highlighted

George Rider

Executive Director

George functions as general manager of the WVSMA and oversees all staff functions; prepares and recommends the annual budget with the aid of the finance manager and oversees its implementation; recommends programs to the Executive Committee and Council; coordinates legislative activities; works with outside legal counsel; interacts with the Board of Medicine and the various publics; and supervises building maintenance and operations.

Nancie Divvens

Associate Executive Director

Nancie assumes the responsibilities of the executive director in his absence and serves as office manager; assists the Executive Committee and Council in carrying out the policies in the Constitution and Bylaws; coordinates the WVSMA Continuing Medical Education Accreditation Program, the Annual Meeting, the Mid-Winter Clinical Conference, and Speakers' Bureau; serves as the WVSMA liaison for Nationwide Insurance Company-Medicare Operations; and develops non-dues revenue programs; administers travel policies for educational meetings; and directs two worldwide travel programs for members.

Teresa Crouch

Receptionist

Teresa answers and directs telephone calls; coordinates registration for the Annual Meeting and the Mid-Winter Clinical Conference; orders and keeps inventory of office supplies; maintains office equipment; types correspondence for the *West Virginia Medical Journal;* opens and distributes mail; assists with special projects; and runs weekly computer backups of all office files.

Michelle Ellison

Public Relations/ Advertising Manager

Michelle coordinates all public relations functions for the WVSMA; writes news releases; designs brochures and promotional materials; creates the monthly publication *Medical Newsline;* works with the finance manager to maintain all advertising accounts for the *West Virginia Medical Journal;* recruits new advertisers for the *Journal;* interacts with the managing editor to determine advertising placement; proofreads advertising copy; serves on the Publication Committee; updates the subscriber mailing list for the *Journal;* and acts as a liaison with county medical societies in developing mini-internship programs.

Nancy Hill

Managing Editor/ WV Medical Journal

Nancy writes news articles, edits and proofreads all copy, designs the layout of the pages, and takes photographs for the *West Virginia Medical Journal,* the WVSMA's monthly magazine; works with the editor, public relations/advertising manager and printer on various production aspects of the *Journal;* prepares financial statements regarding the *Journal* if needed; assists staff members with proofreading and creating news releases, correspondence, advertisements, brochures and other publications; and serves on the Publication Committee.

Shirleen Lipscomb

Executive Secretary

Shirleen functions as general assistant to the executive director, associate executive director, Executive Committee and Council; performs clerical duties, handles routine information and inquiries related to the daily operation of the WVSMA; coordinates the Physicians Protection (Loss Control) Program through MCIG for WVSMA's endorsed carrier CNA Insurance Companies; coordinates visits of the WVSMA president and WVSMA staff members to the component societies; and assists in the planning and registration at the Annual Meeting, the Mid-Winter Clinical Conference and all other seminars and workshops sponsored by the WVSMA.

Winnie Martin

Director of Government Relations

Winnie serves as executive secretary to the WVSMA Auxiliary and to WESPAC, the West Virginia Medical Political Action Committee; manages government relations by researching and analyzing legislative issues, lobbying the Legislature, monitoring interim committee meetings, and assisting with the WVSMA Legislative Committee; serves as liaison to the Council; writes and edits *WESGRAM*, WVSMA's bimonthly publication, *Legislative Update,* a weekly newsletter produced while the Legislature is in session, and *MedLink,* the WVSMA Auxiliary's quarterly newsletter.

Sue Shanklin

Finance Manager

Sue manages all WVSMA finances including the recording of all assets, liability, fund balance, accounts receivable and accounts payable transactions; prepares weekly checks for operating disbursements; makes bank deposits and manages investments as needed; maintains biweekly payroll and employee vacation and sick leave records; prepares monthly general ledger, trial balance and profit and loss statement; assists and supplies financial data to auditing firm for preparing annual audit and annual tax returns; compiles quarterly tax returns, annual operating budget and financial statements for the treasurer, Executive Committee and Council; invoices *Journal* advertisers on a monthly basis; serves on the Finance, Audit and Investment Committee; and manages employee benefits.

Donna Webb

Membership Coordinator

Donna keeps dues and informational records on all active, retired and student members; acts as WVSMA's liaison with AMA for membership activities; compiles and creates roster for members; recruits new members; interacts with county societies on membership matters; assists with special projects; serves as exhibit manager for the Annual Meeting and the Mid-Winter Clinical Conference; and updates mailing lists and prepares labels as requested by staff members and other organizations.

An overview of the AMA Annual Meeting

Members of the WVSMA's delegation at the AMA Annual Meeting included WVSMA Council Chairman Dr. Constantino Amores, Dr. Robert Hess, Dr. James Bryant, Dr. David Avery, Dr. Norman Taylor, WVSMA Associate Executive Director Nancie Divvens, WVSMA President Dr. Robert Pulliam, Dr. John Holloway (seated), and WVSMA President-Elect Dr. James Comerci.

The WVSMA's delegation met in Chicago, June 13-17, for the AMA Annual Meeting. We were pleased to have four medical student leaders with us who did a wonderful job of representing our state: Mark Wright, WVSMA-MSS president; Myra Wilkerson, WVSMA-MSS secretary/treasurer; Joseph Touma, WVU-Charleston Chapter president; and Kevin Kaufman, WVSMA-MSS immediate past president.

The media event was certainly the speech by Mrs. Clinton. She said everything we wanted to hear; freedom of choice, autonomy, less hassles, but none of the details were discussed. There was no opportunity to ask questions or get specifics.

There were 229 resolutions and 117 reports debated by nine reference committees at the meeting. Our delegation covered the committees and took an active role in the discussions.

The AMA House of Delegates came out strongly opposed to price controls, global budgets, and in favor of collective bargaining over state-level medical global budgets. The House even approved possible litigation against federal global budgets. A proposal for physician bargaining groups is undergoing refinement for the AMA Interim Meeting in December. Our delegation had a private meeting with several of the AMA staff and board members to make them aware of our problems in West Virginia. This led to a follow-up meeting with them and, needless to say, we gained their attention. They have promised their assistance and we will hold them to that.

It was agreed by the House of Delegates that there must be an increase in the availability of primary care. However, no one has yet been able to define who primary care physicians are. This will be a future debate I'm sure.

The AMA is, and strongly remains, opposed to the National Practitioner Data Bank. Their support is to the Federation of State Medical Boards Action Data Bank, which is a much better system. In addition, it was agreed that major changes in the RBRVS are needed and the AMA is working toward these goals.

The numerous board reports are excellent resource materials and I would strongly encourage their use. They are available at the WVSMA office, as well as with each delegate.

On behalf of the delegation, Drs. James Bryant, Robert Pulliam, Norman Taylor, John Holloway, Constantino Amores, Robert Hess, James Comerci and Ms. Nancie Divvens (who did a great job at her first meeting), I hope we represented you well. Please give us your input.

David W. Avery, M.D.
AMA Delegate

An overview of the HMSS Assembly Meeting

The 21st AMA-HMSS Assembly Meeting was held June 10-14 in Chicago with 418 credentialed representatives in attendance. The AMA-HMSS considered 63 resolutions and 14 HMSS Governing Council reports, and their actions included:

22 Resolutions Adopted
10 Governing Council\Board Reports Supported in Lieu of a Resolution
10 Resolutions Referred to the Governing Council
19 Resolutions Not Adopted
2 Resolutions - No Action

Ten resolutions were forwarded to the AMA House of Delegates for consideration at the 1993 Annual Meeting. In addition, the AMA House of Delegates considered five HMSS resolutions which were transmitted from the 1992 Interim Assembly Meeting.

The AMA House of Delegates adopted 13 HMSS resolutions and referred two resolutions to the Board of Trustees. Although space does not permit a full report on each of the actions I have mentioned, a brief summary of several I feel are important are as follows:

1. **Governing Council (GC) Report L - Funding for Federally-Sponsored Health Plans**

   HMSS Action - Adopted GC Report L which recommended that the AMA-HMSS delegate be instructed to support Board of Trustees' Report S.

   HOD Action - Adopted recommendation in Board of Trustees' Report S and filed the remainder of the report.

   Board of Trustees' Report S recommendations state:

   The Board of Trustees recommends that Resolution 102 (I-92) be adopted. Resolution 102 calls upon the AMA to support the concept that all health care reform proposals should:

   (1) Include a valid estimate of the implementation cost based on all health care expenditures to be included in the reform; and

   (2) Identify specifically what means of funding will be used to pay for the reform proposed and what the impact will be.

2. **Governing Council Report N - Health Care Rationing**

   HMSS Action - Adopted amended Governing Council Report N which instructed the AMA-HMSS delegate to work for referral of Board of Trustees' Report GG for further action.

   HOD Action - Referred Board of Trustees' Report GG to the Board of Trustees.

   Board of Trustees' Report GG recommends:

   (1) That health care rationing be defined as: "A process of allocating health care resources that explicitly limits or denies medically necessary services or third-party coverage on the basis of pre-determined criteria such as the cost of such services, the patient's age, medical condition and the perceived value to society as a whole;" and

   (2) That policy 165.997 (2) which reads: "The AMA urges the profession to adopt certain objectives as appropriate and desirable in health and medical plans including . . . (c) opposition to rationing" be reaffirmed.

The HMSS Assembly also addressed resolutions that

- -- asked for guidelines for guns in hospitals
- -- increased information on fiscal notes
- -- asked for clarification of JCAHO standard MS 2.5.3.1
- -- asked that the AMA opposed efforts by hospitals to abrogate the voting rights of the physicians who serve on the Medical Executive Committee
- -- asked for a change in AMA policy 225.985 which deals with hospital exclusive contracts and medical staff autonomy.

For more information about the HMSS or about any of the reports or resolutions mention in this report, contact me at (304) 255-1541 or Michael R. Vitek, AMA's director of Hospital Medical Staff Services at (312) 464-5061.

Norman W. Taylor, M.D.
Raleigh General Hospital Delegate to HMSS
Chairman, WVSMA-HMSS Delegation

WESPAC

West Virginia State Medical Association's
Political Action Committee

With so many challenges facing organized medicine, it is imperative that we have support in the Legislature. The need for political action has never been greater!

Write your personal check to WESPAC today and help us strengthen our role in the legislative process.

$50 - Regular **$100 - Sustainer**
$150 - Extra Miler

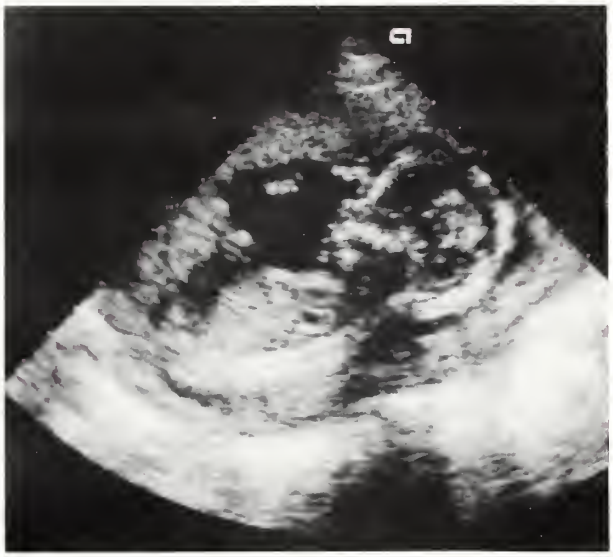
Mail your personal check to:

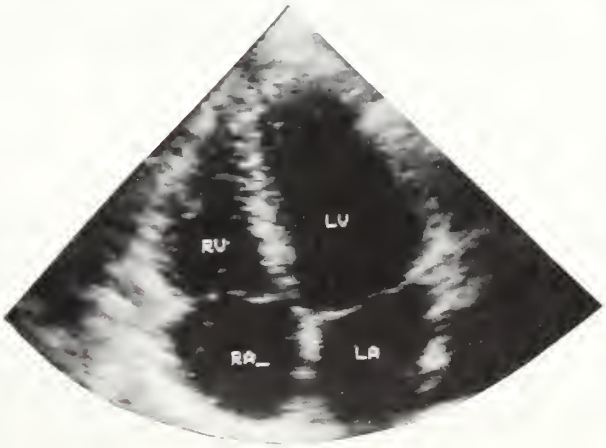
WESPAC
P.O. Box 4106
Charleston, WV 25364

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time





Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

Supraventricular tachycardia: Catheter ablation therapy in 72 patients

RONALD McCOWAN, M.D.
LINDA TONE, R.N.
CLIFF THORPE, C.V.T.
TERRY MILLER, C.V.T.
JANIS KISER, R.N.
LORI HATFIELD, R.N.
Department of Cardiology, Charleston Area Medical Center, Charleston

Abstract

Radiofrequency (RF) catheter ablation for recurrent supraventricular tachycardia (SVT) has been performed at the Charleston Area Medical Center since September 1991. Of the first 72 patients undergoing this procedure, a total of 76 tachycardias were treated and these included 41 accessory pathways, 21 junctionals, and 14 atrial tachycardias (atrial fibrillation, flutter, and intra-atrial reentry tachycardia). RF catheter ablation was successful in 67 of these patients (93%). This procedure is a highly effective treatment modality which should be considered in patients with recurrent symptomatic SVT.

Introduction

Supraventricular tachycardia (SVT) occurs commonly. It may be due to the presence of an accessory electrical pathway in the heart (e.g. Wolff-Parkinson-White Syndrome), atrial fibrillation, atrial flutter, other atrial tachycardias, or a junctional tachycardia (1). Most cases are suppressed with empiric drug therapy and even though patients may have syncope, palpitations or associated chest pain, sudden cardiac death rarely occurs (2).

Until recently, symptomatic, recurrent, and drug refractory SVT was managed by antitachycardia pacing (3) or arrhythmia surgery (4,5). Now, the clinical introduction of radiofrequency catheter ablation (6,7) has practically eliminated the need for such therapy. The utilization of radiofrequency (RF) current in catheter ablation has allowed patients with SVT to have a definitive and relatively simple cure of their arrhythmia and, in most cases, it has obviated the need to continue antiarrhythmic medications.

This report reviews our experience with catheter ablation for SVT using RF current at the Charleston Area Medical Center.

Patients

The 72 patients with recurrent SVT who were treated by RF catheter ablation are listed in Table 1. There were 33 males and 39 females, and the mean age was 43 ±19 years (range 12 years to 86 years).

Structural heart disease was present in 12 (16%) of the patients and included mitral valve prolapse (two patients), dilated cardiomyopathy (three patients), rheumatic heart disease (two patients), and coronary disease (four patients). Sixty-four patients (89%) had previously taken antiarrhythmic medications (mean of 3 ± 2 drugs per patient, range 1 to 7).

The indication for catheter ablation was recurrent symptomatic SVT. The SVT was associated with syncope (12 patients) and other symptoms (near syncope, palpitations, chest pain, and dyspnea). Symptoms had been present for a mean of 12 ± 12 years (6 months to 50 years). No patient had experienced a cardiac arrest.

Methods

Catheter ablation procedures were immediately preceded by electrophysiologic testing which was performed using the previously described techniques (8). Prior to and during the ablation procedure, the patients were sedated with intravenous midazolam (2 to 3 mgs. every 30 to 60 minutes) and/or fentanyl (25 to 75 ugrams every 30 minutes). In addition to a multipolar electrode catheter being passed into the right atrium, right ventricle, and the His bundle region via the right femoral vein, a multipolar catheter was passed into the coronary sinus via the left subclavian vein.

Heparin, 3,000 to 5,000 units, was given intravenously with 1,000 to 2,000 units being given each hour thereafter. An activated clotting time (ACT) was assessed each hour in patients having catheters positioned in the left ventricle. Heparin boluses were given to achieve an ACT of > 250 seconds. Induction of the clinical SVT and determination of its mechanism were then pursued.

Accessory pathways were localized using the surface electrocardiogram and endocardial catheter mapping of the coronary sinus and right atrium (9). A steerable large (4 millimeter) tipped multipolar electrode catheter was then directed to the atrial or ventricular myocardium at the area of tachycardia origin. Left-sided accessory pathways (located around the mitral valve annulus) were localized by passing the steerable catheter across the aortic valve and manipulating the catheter along the mitral valve annulus. Right-sided (located around the tricuspid valve annulus) and septal pathways (located in the anterior and posterior interatrial septal regions) were approached by positioning the catheter along the tricuspid valve annulus from the right femoral or left subclavian vein.

In patients having junctional tachycardias (atrioventricular nodal reentry tachycardia (AVNRT) and atrial fibrillation, the steerable catheter was manipulated into the posterior and anterior regions of the interatrial septum, respectively, for ablation. In addition, catheter mapping of the right atrial myocardium was carried out in the patients with atrial flutter and intra-atrial reentry tachycardia.

Radiofrequency current was then applied to the region of tachycardia origin via the catheter tip and a cutaneous patch electrode placed on one of the patient's thighs. Power settings of 20 to 54 watts were applied to the myocardium for 10 to 60

Table 1. Patients With Recurrent SVT Undergoing RF Catheter Ablation At CAMC

Pt.	Sex	Age	Symptom?	#Drugs	SVT	^Apps	E	S/F	Follow-up
1	F	42	NS	2	AP	24	38w	F	22 months
2	F	59	P	1	N	27	30w	S	20 months
3	M	34	NS	2	AP	18	45w	S	19 months
4	F	71	P	7	AF	19	47w	S	22 months
5	F	24	S	7	AP	7	25w	S	22 months
6	M	40	P	1	AP	22	42w	S	20 months
7	F	40	P	7	N	12	42w	S	20 months
8	M	48	NS	1	*AP	27	42w	S	20 months
9	F	16	NS	3	N	15	40w	S	20 months
10	M	58	P	3	N	27	25w	S	19 months
11	F	38	P	3	+N	25	40w	S	20 months
12	M	57	P	4	AP	11	40w	S	19 months
13	F	30	P	7	AP	32	48w	S	19 months
14	M	57	NS	3	AP	25	45w	S	19 months
15	M	77	P	6	AF	28	30w	S	20 months
16	F	19	P	1	AP	3	25w	S	16 months
17	M	29	P	0	AP	30	20w	S	14 months
18	F	70	D	6	AF	10	37w	S	17 months
19	M	23	P	2	AP	1	35w	S	18 months
20	F	72	S	1	AP	4	35w	F	18 months
21	F	19	P	3	AP	4	25w	S	19 months
22	M	37	P	1	AP	9	30w	S	19 months
23	M	38	NS	3	AP	43	35w	S	14 months
24	M	67	CP	0	AP	21	35w	F	18 months
25	M	58	D	2	AF	3	35w	S	18 months
26	F	15	P	3	-AP	2	30w	S	19 months
27	M	73	NS	2	N	17	20w	S	14 months
28	F	27	P	0	N	9	20w	S	15 months
29	F	61	CP	7	AF	2	30w	S	14 months
30	F	22	NS	2	AP	9	30w	S	14 months
31	F	32	NS	1	AP	43	30w	S	15 months
32	F	35	NS	2	AP	25	35w	S	8 months
33	M	86	P	5	AFL			S	8 months
34	M	35	D	4	AP	41	40w	F	8 months
35	M	33	P	2	AP	20	35w	F	8 months
36	F	74	P	4	AF	18	35w	S	7 months
37	M	62	P	3	AP	14	30w	S	7 months
38	M	45	NS	1	AP	5	25w	S	7 months
39	F	61	D	5	AF	2	30w	S	7 months
40	M	34	P	2	AP	2	25w	S	7 months
41	F	51	P	3	N	9	20w	S	16 months
42	M	58	P	7	AF	5	30w	S	6 months
43	M	18	P	0	@AP	14	30w	S	9 months
44	M	13	S	1	AP	30	30w	S	15 months
45	F	18	S	1	N	8	20w	S	6 months
46	M	45	P	1	AP	7	25w	S	6 months
47	M	72	S	6	AF	4	30w	S	6 months
48	M	44	P	3	AP	14	30w	S	6 months
49	M	16	P	0	N	10	20w	S	4 months
50	M	47	P	1	AP	21	40w	S	4 months
51	F	30	P	1	N	29	25w	S	3 months
52	F	31	P	2	N	3	20w	S	15 months
53	F	40	NS	3	N	57	30w	S	12 months
54	F	54	P	3	N	12	30w	S	11 months
55	F	47	P	5	AP	4	40w	S	12 months
56	M	42	S	1	AP	52	35w	S	12 months
57	F	48	P	3	N	2	25w	S	12 months
58	F	61	NS	1	N	4	25w	S	12 months
59	F	57	NS	2	N	8	20w	S	11 months
60	M	67	P	4	AP	19	40w	S	11 months
61	F	12	P	2	AP	45	54w	S	11 months
62	F	42	P	3	N	22	30w	S	3 months
63	F	68	P	1	AT	8	25w	S	3 months
64	F	22	NS	2	AP	16	30w	S	3 months
65	F	57	D	6	AT	4	25w	S	1 month
66	M	32	P	3	AP	25	35w	S	1 month
67	M	22	P	0	AP	20	40w	S	1 month
68	F	31	P	1	AP	16	40w	S	1 month
69	F	52	S	2	AP	6	35w	S	1 month
70	M	43	P	3	AP	2	30w	S	1 month
71	F	59	NS	6	AF	1	25w	S	1 month
72	F	14	P	0	N	32	25w	S	1 month

- number of antiarrhythmic drugs taken prior to procedure
^apps - number of RF current applications during the procedure
? - symptoms (NS - near syncope, P - palpitations, CP - chest pain, D - dyspnea, S - syncope)
* - pt. had four different SVTs: atrial fibrillation, and junctional, intra-atrial, and accessory pathway tachycardias
+ - pt. had junctional tachycardia and atrial flutter
- - pt. developed intermittent AV dissociation
@ - pt. had junctional and accessory pathway tachycardias
AP - accessory pathway
N - nodal or junctional tachycardia (AVNRT)
AF - atrial fibrillation
AFL - atrial flutter
AT - atrial tachycardia
E - maximum RF energy used (w - watts, measure of RF power, S/F - success/failure)

seconds using a commercially-available radiofrequency current generator. RF current was usually applied during the SVT except for accessory pathways where the current was frequently applied during sinus rhythm (Figure 1). Disappearance of the delta wave suggested a successful ablation procedure.

Patients were observed for 30 to 45 minutes after the catheter ablation procedure for return of ECG evidence of accessory pathway conduction or inducibility of the SVT. The end point of the procedure was an inability to induce the tachycardia. Isoproterenol was infused, in some cases, to facilitate re-induction of the SVT. Early in our experience, the MB fraction of serum creatine phosphokinase (CKMB) was assessed every eight hours for 24 hours. This has been discontinued due to the cost and limited usefulness for this particular application.

After the ablation procedure, patients were monitored on a telemetry floor for 24 to 36 hours and

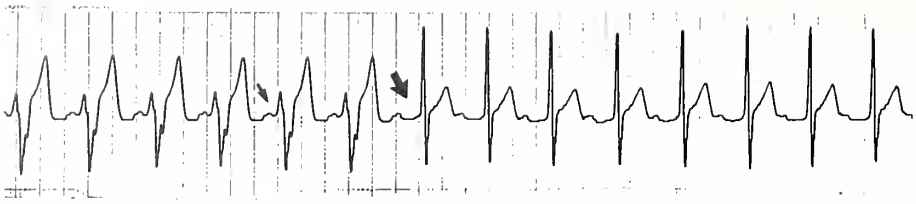


Figure 1. Applications of RF current during sinus rhythm in a patient with WPW syndrome. Small arrow shows short PR interval and delta wave while large arrow points out the loss of the delta wave signifying ablation of the accessory pathway.

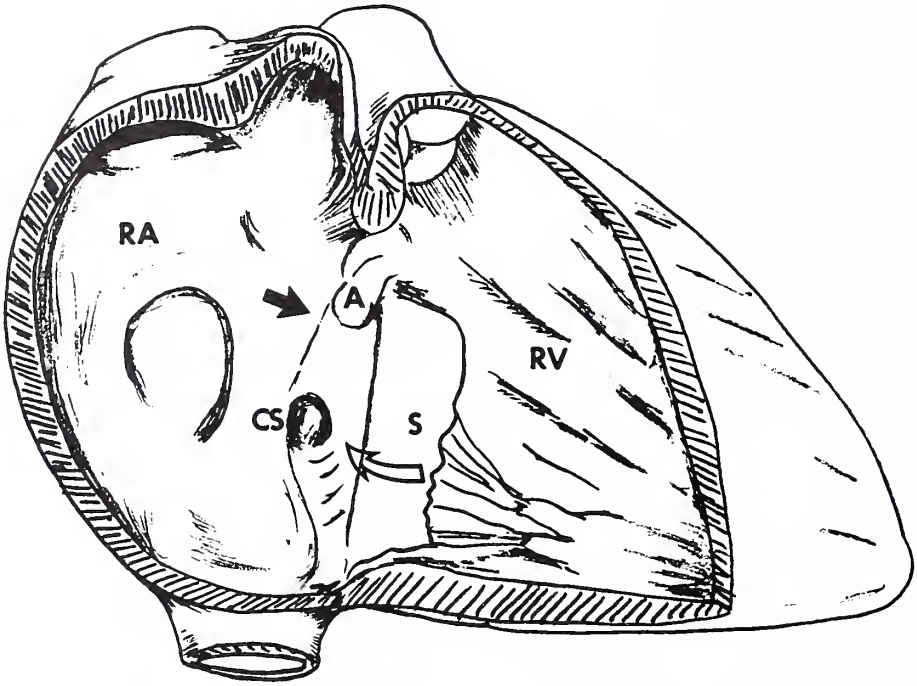


Figure 2. Sites of ablation along the interatrial septum. Open arrow - posterior ablation site for junctional tachycardia. Filled arrow - anterior ablation site for junctional tachycardia. RA - right atrium, CS - coronary sinus, A - AV node, S - septal leaflet of tricuspid valve, and RV - right ventricle.

then discharged home. However, patients undergoing complete AV nodal ablation for atrial fibrillation or flutter had a permanent pacemaker implanted 48 hours after the ablation procedure and were discharged 24 to 48 hours thereafter. Aspirin, 5 grains daily, was prescribed for four to six weeks and antiarrhythmic medications were not resumed (if the ablation procedure was successful).

Results

Electrophysiologic testing revealed the presence of 41 accessory pathways in 40 patients. There were 27 left-sided, seven right-sided, and seven septal pathways. Thirty-six of these 40 (88%) patients having accessory pathways had a successful catheter ablation procedure. The mean heart rate of the SVT in this group of patients was 190 beats/minute (bpm).

All 21 patients with AVNRT had a successful catheter ablation procedure. The mean rate of the AVNRT was 181 bpm. All of these patients had the common form of AVNRT except one who had the uncommon form (10). Selective ablation of the fast pathway (Figure 2) was performed in eight patients, with nine of the patients undergoing a slow pathway ablation. In four patients, both approaches were utilized for a successful procedure.

Complete AV nodal ablation for atrial fibrillation or flutter was successful in all 11 patients and all of these patients had implantation of a permanent pacemaker. A VVIR pacemaker was implanted in two patients and a DDDR pacemaker was implanted in nine patients. The VVIR pacemakers were later upgraded to DDDR devices due to the development of pacemaker syndrome. Three patients had an intra-atrial reentry tachycardia which was ablated with RF current applications to the right atrial wall.

Two ablation procedures were required in 13 (18%) of the 72 patients to achieve a successful result, and three procedures were required for one patient. The procedures lasted a mean of 3.4 ± 2 hours (range 1 hour to 9 hours). The CKMB level was measured in 27 (42%) patients and measured 12 ± 8 units (normal 0 to 7).

Follow-up

We have been able to follow the progress of all of the patients, except for four of them, for a mean of 12 ± 6 months. Eleven (15%) of the patients reported a recurrence of palpitations, however, 55% of these patients stated episodes were brief (a few seconds to 2-3 minutes) and not as severe as before the ablation procedure.

Total relief of SVT symptoms was reported in 85% of these patients subsequent to the ablation procedure. Three patients (4%) who had a successful procedure were taking antiarrhythmic medications during the follow-up period. Only one of these patients complained of recurrent symptoms.

Of the five patients in which the procedure failed, two were lost to follow-up. The other three patients remained on antiarrhythmic medications, with two of them reporting recurrent SVT.

Complications

During the procedure and early in our experience, two patients developed complete heart block.

The first patient was a 40-year-old female with rheumatic mitral stenosis and recurrent AVNRT who developed complete heart block with ablation of the fast AV nodal pathway. Implantation of a permanent pacemaker was required. The second individual to experience this complication was a 68-year-old male with a previously implanted atrial antitachycardia pacemaker and bifascicular heart block (right-bundle branch block and left anterior hemiblock). He developed complete heart block during ablation of a left-sided accessory pathway and a DDD pacemaker was subsequently implanted.

There were also complications in two other patients. A 15-year-old female with pre-existing intermittent

Mobitz II second degree AV block developed intermittent asymptomatic AV dissociation after ablation of a right posterior accessory pathway. The other individual with complications was a 40-year-old female with WPW syndrome and a left lateral pathway who developed cardiac tamponade. This condition was managed by pericardiocentesis.

Discussion

Although antiarrhythmic drug treatment remains the cornerstone of SVT treatment, the development of RF catheter ablation has dramatically changed the management approach to supraventricular arrhythmias.

In our experience, 93% of the 72 patients presenting with an SVT had a cure of their arrhythmia, although, in 18% of the patients a second ablation procedure was required. Complications occurred in 5% of the patients, which included a 2% incidence of complete heart block. Antiarrhythmic drugs could be discontinued completely in 64 (95%) of the 67 patients having a successful ablation procedure. These results compare favorably with reports generated by larger referral centers where success rates range from 85% to 99% (11).

RF ablation involves manipulation of an electrode catheter to a focus of tachycardia origin in the heart. RF current is delivered to the tissue with resultant tissue heating and desiccation. Small 1-2 millimeter areas of scar subsequently form at this site. These areas of scar have, thus far, not been shown to be arrhythmogenic. The present approach, however, is to limit, as much as possible, the number of RF current applications and therefore the amount of scar formation.

The indications for RF catheter ablation treatment in patients with SVT can be discussed in terms of the different patient subgroups. Patients having WPW syndrome, in our opinion, should have one or more episodes of symptomatic SVT prior to undergoing an ablation procedure. The younger the patient the less emphasis is placed on whether or not antiarrhythmic medications have been utilized prior to considering RF ablation. Lifelong antiarrhythmic drug therapy with its possible attendant side effects and cost is less desirable. However, older patients with WPW syndrome who have good control (e.g. 2-3 minimally symptomatic episodes/year) may be considered for continued medical therapy. RF ablation for WPW syndrome is usually not recommended in asymptomatic patients.

The indication for RF ablation in a patient with a junctional tachycardia is, in general, the same as that of the WPW syndrome. Successful treatment for AVNRT may be achieved with ablation of either the fast or the slow AV nodal pathways. The fast pathway approach was reported initially and has been associated with up to a 9% incidence of complete heart block. Patients may also develop a first-degree AV block. The slow pathway approach, although more technically challenging, is usually not associated with the development of a first-degree AV block and markedly reduces the chance for complete AV block. We now primarily utilize a slow pathway approach.

The indication for RF ablation in atrial fibrillation is for control of a rapid ventricular rate. These patients should have failed a number of antiarrhythmic medications since the procedure is done to create complete heart block with the need for permanent pacemaker implantation. Accordingly, the patients undergoing RF ablation for this indication represent a small group in our patient population. Atrial flutter is generally approached in a similar fashion although some of these patients may be treated effectively by applying RF current directly to the atrial myocardium with subsequent elimination of the atrial flutter (12). We attempted this in one patient, but atrial flutter recurred and complete AV nodal ablation was required.

Of the 11 patients undergoing RF ablation for atrial fibrillation or flutter, all eventually had implantation of a DDDR pacemaker. Pacing of the atrium and restoration of AV synchrony are both thought to play a role in preventing recurrent atrial fibrillation. Recent advancements in pacemaker technology have provided a means to handle recurrent atrial arrhythmias without the need to reprogram the pacemaker to a ventricular demand mode. Such options include the DDI pacing mode, automatic mode switching (DDDR to VVIR mode), and the conditional tracking limit (13).

Conclusions

In our experience with radiofrequency catheter ablation as a treatment for SVT, we have found the procedure to be associated with a high rate of success and few complications. It should be considered as a definitive treatment in patients having symptomatic recurrent SVT.

References

1. Marriot HJ, Myerburg R. Recognition of cardiac arrhythmias and conduction disturbances. In: Hurst J, Schlant R, editors. The heart. New York: McGraw-Hill;1990: 495-506.
2. Wang Y, Scheinman M, Chein W, et al. Patients with supraventricular tachycardia presenting with aborted sudden death: incidence, mechanism and long-term follow-up. J Am Coll Cardiol 1991;18:1711-9.
3. Fisher JD, Johnston D, Kim SG, et al. Implantable pacers for tachycardia termination: stimulation techniques and long-term efficacy. PACE 1986;9:1325-33.
4. Cox JL, Gallagher JJ, Cain ME. Experience with 118 consecutive patients undergoing operation for the Wolff-Parkinson-White syndrome. J Thorac Cardiovasc Surg 1985; 90:490-501.
5. Lawrie GM, Lin HT, Wyndham CC, et al. Surgical treatment of supraventricular arrhythmias. Results in 67 patients. Ann Surg 1987;205:700-11.
6. Jackman WM, Wang X, Friday KJ, et al. Catheter ablation of accessory atrioventricular pathways (Wolff-Parkinson-White syndrome) by radiofrequency current. N Engl J Med 1991;324:1605-11.
7. Calkins H, Sousa J, El-Atassi R, et al. Diagnosis and cure of the Wolff-Parkinson-White syndrome or paroxysmal supraventricular tachycardia during a single electrophysiologic test. N Engl J Med 1991; 324:1612-18.
8. McCowan R. Electrophysiologic studies: recent experience at the Charleston Area Medical Center. W Va Med J 1991;7:108-12.
9. Waldo A, Ahktar M, Benditt D, et al. Appropriate electrophysiologic study and treatment of patients with the Wolff-Parkinson-White syndrome. JACC 1988;11: 1124-9.
10. Sung R, Styperek J, Myerburg R, et al. Initiation of two distinct forms of atrioventricular nodal re-entrant tachycardia during programmed ventricular stimulation in man. Am J Cardiol 1978;42:404-15.
11. Scheinman M. Radiofrequency catheter ablation for patients with supraventricular tachycardia. PACE 1993;16:671-9.
12. Cosio F, Goicolea A, Lopez-Gil M, Arribas F. Catheter ablation of atrial flutter circuits. PACE 1993;16:637-42.
13. Barold S, Mond H. Optimal antibradycardia pacing in patients with paroxysmal supraventricular tachyarrhythmias: role of fallback and automatic mode switching mechanism. In: Barold S, Mugica J, editors. New perspectives in cardiac pacing. New York, Futura;1993:483-518.

Safety belt use and hospital charge differences among motor vehicle crash victims

MITCHELL C. SOKOLOSKY, M.D.
JOHN E. PRESCOTT, M.D., F.A.C.E.P
SUSAN L. COLLINS, R.N., M.S.N.
GREGORY A. TIMBERLAKE, M.D., F.A.C.S.
Center for Rural Emergency Medicine and the Jon Michael Moore Trauma Center, West Virginia University School of Medicine, Morgantown

Abstract

Trauma remains a leading cause of death and disability in America, and motor vehicle crashes (MVC) are the most common cause of serious injury in West Virginia. In this study, we examined the role of seat belt use or non-use in the death, disability, and hospital charges of 500 patients admitted after MVC to a rural Level 1 trauma center in 1990. Eighty percent of the patients who required hospitalization did not use seat belts. The unbelted patients had a 34% higher injury severity score, a 97% increase in the need for extended care after discharge from the hospital, and a 186% increase in hospital charges compared to belted patients. Our study concluded that seat belt use among motor vehicle crash victims reduced their hospital costs, and improved their outcome as compared to those patients not wearing seatbelts.

Introduction

Trauma is the leading cause of death and disability for Americans between the ages of 1 to 45 years (1), and motor vehicle crashes are the most common cause of death for individuals up to the age of 44. In addition, motor vehicle crashes are responsible for the majority of spinal cord injuries and are the single leading cause of severe brain injury. In 1989 alone, motor vehicle crashes resulted in 46,900 deaths and 1.7 million disabilities, with 140,000 of these individuals becoming permanently disabled (1,2).

The cost of motor vehicle crashes involving fatalities or injuries was $37 billion in 1989 (3). This figure does not include the cost to employers and public agencies. Hospitals, insurance companies, and medical personnel shoulder the financial burden when crash victims are under or uninsured. Some of the cost may be shifted to insured patients through increased hospital charges which leads to increased insurance rates.

While the majority of U.S. citizens live in urban areas, almost 70% of trauma fatalities occur in rural regions and most often are the result of motor vehicle crashes (4). The data indicates that the typical fatal crash involves a single vehicle on a rural road at night (5), which suggests that people living in rural states, such as West Virginia, are at an increased risk of being fatally injured from a crash simply due to where they live.

Safety belts have been shown to significantly reduce injury severity and fatalities (3,6-8). They have been shown to reduce motor vehicle fatalities and serious injuries by 55%-60% (6,9). In addition, one study found that safety belts reduced hospital admissions from crashes by 65% and hospital charges by 67% (10).

The study we conducted was designed to compare the injury severity, length of hospital stay, hospital charges, reimbursement, and discharge disposition between belted and unbelted occupants of motor vehicle crashes in West Virginia, a state which will not have an adult seat belt law until September 1.

Methods

Records of all patients who were admitted in 1990 to the Jon Michael Moore Trauma Center following a motor vehicle crash were reviewed. Data was collected from the hospital's trauma registry and billing records. The trauma registry is a computerized prospective data collection system used to maintain records of all patients who require hospitalization following an injury. The billing records utilized in this study were limited to hospital charges and did not include physicians' fees, follow-up care, or rehabilitation.

All patients who were hospitalized following a motor vehicle crash, whether they were a driver or a passenger, were included in this study. For data analysis, the patients were divided into two groups, belted (B) and non-belted (NB). Data collected included the patient's demographic information, injury severity score (ISS), alcohol level (ETOH), drug screen, emergency department disposition, hospital length of stay (LOS), hospital discharge disposition, and financial information. Injury severity was based on the standard injury severity scoring (ISS) system. The drug screen tested for the presence of amphetamines, barbiturates, benzodiazapines, cannabinoids, cocaine, opiates, and PCP. Survivors were either discharged home or to an extended care facility, skilled nursing or residential facility.

Results

In 1990, 500 patients were admitted to a rural Level 1 trauma center following motor vehicle crashes. As shown in Figure 1, 99 (20%) of these patients were belted (B), and 401 (80%) were non-belted (NB).

The majority (65%) of these patients were between 18 and 40 years old regardless of restraint status. Males comprised 58% of the B patients and 59% of the NB patients. The B patients were admitted directly to the floor 89% of the time and to the Intensive Care Unit 3% of the time, while the NB group was admitted directly to the floor 79% of the time and to an intensive care unit 10% of the time. The B group and NB group were admitted directly to the operating room 8% and 11% of the time respectively.

There was a 34% increase in the mean ISS scores of the NB patients

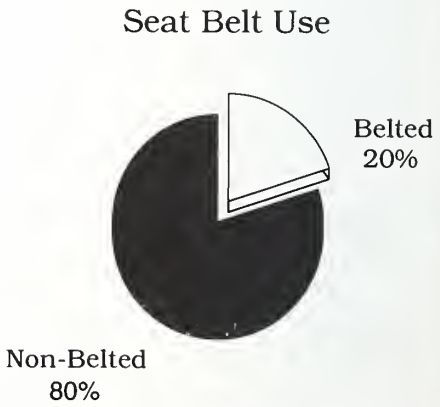


Figure 1. Seat belt use among 500 patients admitted to a rural Level 1 trauma center

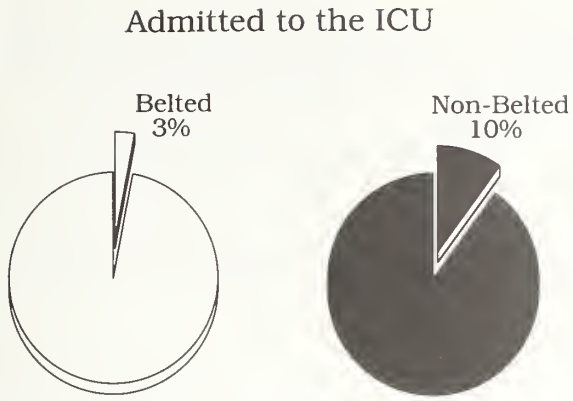


Figure 2. Differences in seat belt use among patients requiring admission to the Intensive Care Unit

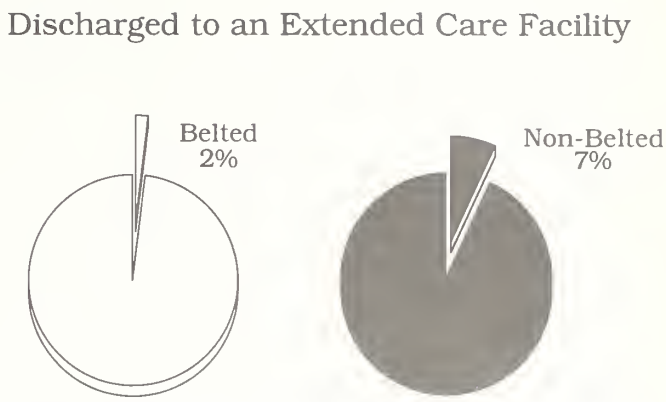


Figure 3. A comparison of frequency of discharge to an extended care facility between belted and non-belted motor crash victims

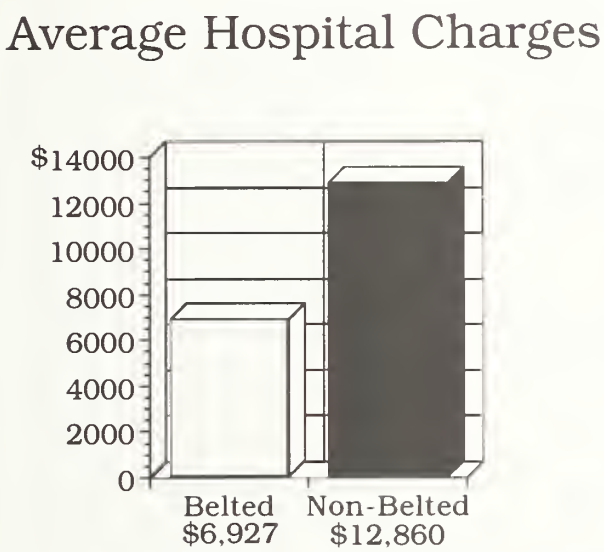


Figure 4. A comparison of average hospital charges between belted and non-belted patients

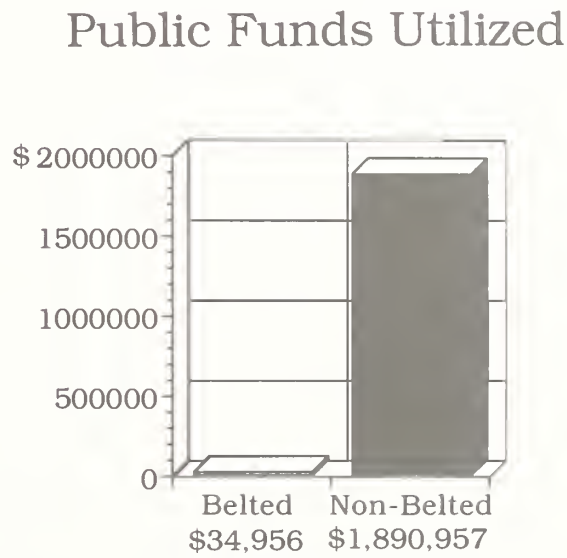


Figure 5. Differences in use of public funds to pay hospital charges between belted and non-belted patients

(ISS=10.9) compared to the B patients (ISS=8.1). Alcohol levels > 100 mg./dl. were similar between the two groups (NB=27% B=21%). Thirteen percent of the B patients had positive urine drug screens while 12% of the NB individuals tested positive.

A total of 2,349 hospital days (an average of 5.9 days/pt.) were required for the NB patients. Of these NB patients, 65 required 503 total ICU days. Belted patients required a total of 298 hospital days (an average of 3.0 days/pt.) with 53 total ICU days for only six individuals in this group (Figure 2). While most (91%) of the patients in both groups were discharged home, 7% of the NB patients were transferred to an extended care facility compared to 2% of the B patients (Figure 3). Mortality rates for both groups were 3%.

There were substantial differences in hospital charges between the two groups. The average hospital charge for the B patients was $6,927 compared to $12,860 for the NB group (Figure 4). Ninety-one percent of hospital charges were collected from the B group, while only 56% was collected from the NB group. Public funds (Medicare and Medicaid) were billed $34,956 for the B group and $1,890,957 for the NB group (Figure 5).

Discussion

Several studies have demonstrated the significant societal burden from non-use of safety belts. This burden includes morbidity, mortality, and cost of medical care (3,6,8).

A Chicago study revealed a 60% reduction in the severity of injury, a 64.4% decrease in hospital admissions, and a 66.3% decline in hospital charges when patients were belted (2). A Tennessee study reported a significant increase in the rate of hospitalization for the non-belted patients (NB=59% B=26%) (3). The average length of stay at the hospital has been reported as much as 2.6 times higher for non-belted individuals. The cost for care of the non-belted patients was also markedly increased (NB=$9,631 B=$3,429) (8). A Kentucky study revealed that it costs 138% more

to care for the non-belted crash victims (NB=$18,165 B=$7,634) (9).

Our data reiterates these findings in the group of patients we studied requiring admission to the hospital. We found that safety belt use decreased the mean ISS scores by 34% (NB=10.9 B=8.1), reduced the average hospitalization length by half (NB=5.9 days B=3.0 days), and decreased average hospital charges by 86% (NB=$12,860 B=$6,927). In addition, we also demonstrated the significant societal financial burden from public funds for caring for the non-belted patients (NB=$1,890,957 B=$34,956). The collection rate for the belted patients was 91% compared to only 56% for the non-belted. Ultimately, the general public is responsible for the payment of these unpaid accounts, either directly through financial support of public entitlement programs such as Medicare and Medicaid, or indirectly through hospital cost shifting or increased hospital charges for paying patients.

The West Virginia Legislature has addressed the need for a mandatory safety belt legislation multiple times before enacting a law which will become effective September 1, 1993. The fact that it has taken several years for a law to be passed can be attributed to the commonly cited arguments against mandatory safety belt use, including the violation of one's personal liberties or civil rights, and the misconception that safety belts cause injuries (10).

Injuries can occur even if safety belts are used and safety belts may even be associated with specific injury patterns. However, one study concluded that of the belted occupants who were seriously injured or killed, it appeared that the injuries were due to improper placement of the safety belts on the anatomy (1). Furthermore, it is generally believed that patients surviving with injuries caused by using safety belts would not have otherwise have survived the crash, and only 0.5% of crashes result in fire or submersion of the vehicle (7).

While enacting a seatbelt use law does not assure use of restraints, a New York state study reported that safety belt use increased from 11.2% to 53% after the restraint law was enacted (12).

In closing, our study demonstrated that safety belt use among admitted motor vehicle crash patients reduced morbidity, mortality, and hospital cost. A more comprehensive study looking at all patients presenting to the Jon Michael Moore Trauma Center from motor vehicle crashes that would include those treated and released, may indicate an even greater benefit from wearing seat belts.

Acknowledgement

The authors wish to thank Sherry L. Laird, R.N., M.S.N., for her invaluable assistance retrieving the data used in this study.

References

1. National Safety Council. Accident facts. Chicago, 1985.
2. Champion HR, Mabee MS. Saving American lives and preventing disabling injuries: impact of state laws mandating safety belt and motorcycle helmet use issues analysis monograph. Reston (VA):TCBO, 1991.
3. Reath DB, Kirby J, Lynch M, Maull KI. Injury and cost comparison of restrained and unrestrained motor vehicle crash victims. J Trauma 1989;29:1173-77.
4. Orsay EM, Turnbull TL, Sunne M, Barrett JA, Langenberg P, Orsay CP. Prospective study of the effect of safety belts on morbidity and health care costs in motor vehicle accidents. JAMA 1988;260:3598-3603.
5. Carson DM, Mellstrom MS. Management of multiple trauma in a rural setting. Minn Med 1987;70:43-5.
6. Holden J, Christoffel THE. A course on motor vehicle trauma: instructor's guide - final report (user's manual). Washington, DC: U.S. Department of Transportation, 1986, DOT Publication No. DOT/OST/P-34:86-150.
7. Hooker EA, et al. Economic impact of motor vehicle restraints in Kentucky: a trauma center's experience. Kentucky Med J 1990;88:59-61.
8. Safety restraint assessment-Iowa: 1987-88. MMWR 1989;38:735-43.
9. Kaplan BH, Cowley RA. Seat belt effectiveness and cost of non-compliance among drivers admitted to a trauma center. American J Emerg Med 1991;9:4-10.
10. Final Rule, FM VSS 208. Occupant crash protection, 48 CPR, Part 571. Washington, DC: National Highway Traffic Safety Administration, 1984.
11. Petrucelli E. Seatbelt laws: The New York experience - preliminary data and some observations. J Trauma 1987;27:706-10.
12. Sato TB. Effects of seat belts and injuries resulting from improper use. J Trauma 1987; 22:754-8.
13. States JD, Annechiarico RP, Good RG, Lieou J, Andrews M, Cushman L, et al. A time comparison study of the New York state safety belt use law utilizing hospital admission and police accident report information. Accid Anal Prev 1990;22:509-21.

Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Medical Grand Rounds

Robert C. Byrd Health Sciences Center of WVU
Edited by Irma H. Ullrich, M.D., Professor of Medicine, Section of Endocrinology and Metabolism

Chlamydia trachomatis genital infections

DISCUSSANT:
MELANIE A. FISHER, M.D
Associate Professor of Medicine, Section of Infectious Diseases, West Virginia University School of Medicine, Morgantown

Abstract

Chlamydia trachomatis genital infections are among the most common sexually transmitted diseases in the United States today. Although these organisms are obligate intracellular pathogens, they more closely resemble bacteria than viruses. C. trachomatis is responsible for considerable morbidity in women, causing urethritis, cervicitis, endometritis, and pelvic inflammatory disease. The latter complication is associated with a high incidence of infertility and ectopic pregnancy, even when the infection is asymptomatic. In young men, C. trachomatis is a common cause of urethritis and epididymitis. Diagnostic tests include tissue culture which has the greatest sensitivity and specificity but is difficult and costly, and various antigen assays which are useful in high-risk, high-prevalence populations. Treatment is effective with doxycycline or erythromycin, but success also depends on appropriate follow-up and empiric treatment of sexual partners. Control of C. trachomatis genital infections is crucial to the control of all sexually transmitted diseases including HIV infection.

Introduction

Genital infections caused by *Chlamydia trachomatis* are among the most common sexually transmitted diseases in the United States today and are responsible for considerable morbidity. The purpose of this paper is to review the microbiology and epidemiology of *C. trachomatis*, the associated clinical syndromes, and the current management of these important infections.

Chlamydiae - Microbiology

Chlamydiae are obligate intracellular pathogens that are considered a form of specialized bacteria. These microorganisms more closely resemble bacteria than viruses because they divide by binary fission, contain a cell wall and also ribosomes, and are inhibited by antibacterial drugs (1).

The genus *Chlamydia* contains three species: *C. trachomatis, C. psittaci, and C. pneumoniae* (formerly TWAR agent). Serotypes or "serovars" D, E, F and G of *Chlamydia trachomatis* cause most *Chlamydia* genital infections, serovars A, B, Ba and C cause trachoma, and serovars L_1, L_2, and L_3 cause lymphogranuloma venereum (LGV). There are 15 known serovars of *C. trachomatis* that are differentiated by microimmunofluorescence.

History of chlamydial diseases

Trachoma has been recognized for centuries as a cause of blindness. In 1907, intracytoplasmic inclusions characteristic of *C. trachomatis* infection were first recognized in conjunctival epithelial cells. In 1910, Lindner described epithelial inclusions in the cervix of a mother whose infant had inclusion conjunctivitis.

Lymphogranuloma venereum was described in 1912 as a separate disease, and in 1938 *C. trachomatis* was isolated in the yolk sac of embryonated eggs. Cell culture techniques introduced by Gordon and Quan in 1965 allowed the further characterization of chlamydiae (2). In 1970, immunotyping of chlamydiae was introduced by Wang and Grayston which allowed differentiation by serotypes (3).

Pathogenesis of infection

Chlamydiae have a complex reproductive cycle composed of two distinct forms. The elementary body is the infective form, is non-dividing, and is adapted for extracellular survival. The reticulate body is adapted to intracellular survival and multiplication.

The elementary bodies attach to the host cell via specific receptors and are endocytosed by the host cell (1). Then the elementary body loses its infectivity and transforms into a reticulate body within eight hours. The organisms undergo binary fission, producing numerous replicates contained in an "inclusion body." After 24 hours of dividing, the reticulate bodies condense and form elementary bodies. The inclusion ruptures, thereby releasing new elementary bodies which become infective again.

To establish infection, therefore, chlamydiae must undergo the following steps:

(1) Attach to human cells;
(2) Induce their own uptake into the cell;
(3) Avoid liposomal fusion;
(4) Change from an elementary body to a reticulate body;
(5) Replicate;
(6) Return to the elementary body stage; and
(7) Leave the host cell by still avoiding the host response (1).

The entire process may require 48 hours, which explains the relatively long incubation period of chlamydial infections (4). Lymphogranuloma venereum (LGV) and non-LGV chlamydial strains vary in their clinical virulence for humans. The attachment of LGV and non-LGV strains involves different cell receptors (1). In vivo, chlamydiae tend to persist for a prolonged period of time.

Table 1. Risk Factors for Chlamydia Genital Infections*

1. An age of 25 years or less
2. New sexual partners within preceding two months
3. Multiple sex partners
4. Presence of purulent or mucopurulent cervical exudate
5. Bleeding induced by swabbing endocervical mucosa
6. Use of no contraception or a non-barrier method
7. History of sexually transmitted diseases

* Adapted from references 11 and 13.

Table 2. Clinical Syndromes Caused By *C. trachomatis*

Women	Men
Urethritis	Urethritis
Cervicitis	Epididymitis
Endometritis	Proctitis
Pelvic Inflammatory Disease	Reiter's Syndrome
Proctitis	
Perihepatitis	
Reiter's Syndrome	

Host cell damage may occur through cytotoxicity (5) or release of liposomal enzymes by macrophages that have ingested the chlamydiae (6). The latter may contribute to the inflammatory response in chlamydial infections (1). Neutrophils inactivate chlamydiae rapidly (7). These elements of the immune response may all contribute to the pathogenesis of inflammation and scarring so characteristic of *C. trachomatis* infections (1).

Epidemiology

C. trachomatis genital infections are the most common bacterial sexually transmitted diseases in the United States today. There are an estimated 3 million - 4 million cases per year (8). During the 1960s and 1970s, the incidence of these infections rose and then stabilized in the 1980s while the incidence of gonorrhea fell. Simultaneous infection with *C. trachomatis* and *Neisseria gonorrhoeae* occurs frequently in both sexes, in 30%-50% of the women with cervical gonorrhea and in 25% of the heterosexual men with gonococcal urethritis.

Chlamydia genital infections are a major cause of morbidity in women. In the United States each year, 2 million women contract cervicitis due to *C. trachomatis*. It is estimated that 25% of them will develop pelvic inflammatory disease (PID). The annual cost of treating *Chlamydia* infection and its complications has been estimated as exceeding $1.4 billion (9). *C. trachomatis* genital infections are estimated to be present in 5% of U.S. women of reproductive age (8); in high risk populations, the prevalence is as high as 25%.

Risk factors for *Chlamydia* infection in women include:

1) An age of less than 25 years;
2) Multiple sex partners;
3) A sex partner who has had multiple partners;
4) History of another sexually transmitted disease;
5) Use of non-barrier contraceptives; and
6) Bleeding inducible by swabbing of the cervical mucosa (10,11) (Table 1).

The sequelae of *Chlamydia* infection in women are significant, with 25% of lower genital tract infections leading to inflammation of the endometrium, Fallopian tubes, and other adnexal structures.

Clinical syndromes

The cervix is the usual initial site of infection in women (Table 2), and only 30% of such women present with symptoms (1).

The cervix may be friable causing vaginal bleeding or post-coital spotting. A high percentage of women with asymptomatic infection presents a major problem for detection and control of the disease. Vaginal discharge is actually uncommon and should suggest other types of infections. The presence of pelvic and/or abdominal pain suggests that the infection has spread beyond the cervix. Bleeding in response to swabbing the cervix is characteristic of *C. trachomatis* infection, and a cervical discharge may be present, either clear or purulent.

The prevalence of *Chlamydia* cervical infection is at least twice as high as that of *Neisseria gonorrhoeae* in the United States (12). Measures for control of this infection have been less effectively applied than for *Neisseria gonorrhoeae* although *Chlamydia* infections became a reportable disease in West Virginia in 1992. *C. trachomatis* causes many similar syndromes in women as does *Neisseria gonorrhoeae* including perihepatitis, also known as the Fitz-Hugh-Curtis syndrome. This complication occurs when the pelvic inflammatory disease (PID) extends to the liver capsule and the perihepatic area. Symptoms include right upper quadrant pain, nausea, vomiting, and/or jaundice. Perihepatitis may occur in the absence of any clinical evidence of PID.

C. trachomatis is an important pathogen causing urethritis in U.S. women (1). It is the most common pathogen isolated from college women with dysuria, frequency and pyuria (greater than or equal to eight white blood cells per high power field) in the absence of enteric pathogens (13). The urethritis may also be asymptomatic; up to 25% of the female patients seen at sexually transmitted disease clinics have had positive cultures from the urethra only. The dysuria, frequency, and urgency are often of more gradual onset than in urinary tract infection caused by enteric bacilli.

Pelvic inflammatory disease is the most serious complication of *Chlamydia* infection in women. It occurs via ascending spread of the organism from the lower genital tract to the cervix, then the endometrium, the Fallopian tubes and finally may produce pelvic peritonitis. *Chlamydia* PID may present with pain and fever or remain completely asymptomatic while continuing to cause local inflammation and scarring. If present, the pain may be mild and is only occasionally severe. There may be cervical motion tenderness and/or adnexal tenderness. A palpable adnexal mass suggests presence of an abscess. If untreated, the PID can lead to pelvic scarring, adhesions, and/or chronic pelvic pain. It has been shown that the pelvic scarring can lead to tubal occlusion with resulting infertility or ectopic pregnancy (1,11). Many cases of PID are caused by more than one organism including *C. trachomatis, N. gonorrhoeae,* anaerobic bacteria (including *Bacteroides* species), and enteric gram negative rods (8).

C. trachomatis causes many clinical syndromes in men similar to those caused by *Neisseria gonorrhoeae (8).* The organism is isolated in 30%-50% of men with non-gonococcal urethritis and post-gonococcal urethritis (1,13). The peak age incidence is in the late teens and early twenties. In general medical settings, about 3%-5% of men are infected, whereas in clinics where sexually transmitted diseases are treated, the incidence may be as high as 15%-20% of heterosexual men.

Among homosexual men, urethral infection is less common but rectal infections are more common.

Chlamydia urethritis is the most common syndrome. As in women, many patients are asymptomatic; one-third of infected males are asymptomatic. Symptoms that may occur include urethral discharge, dysuria, and urethral itching. The presence of four or more polymorphonuclear leukocytes per oil immersion field on a Gram stain of an intraurethral swab specimen suggests urethritis (1). Other suggestive evidence includes the presence of 15 or more leukocytes per high-power field in the sediment of the first 10 mls. - 15 mls. of urine. Gonorrhea should be excluded by a Gram's stain and culture of urethral exudate; *Chlamydia* urethritis will show leukocytes only.

C. trachomatis is the major cause of epididymitis in sexually active heterosexual men 35 years of age or younger (1,8,13). Reiter's syndrome consisting of conjunctivitis, urethritis (or cervicitis in females), reactive arthritis, and a characteristic mucocutaneous lesion, keratodermia blennorrhagia, has been associated with *Chlamydia* infection as well. The urethritis may be subclinical. *C. trachomatis* has been recovered from the urethra in up to 70% of men with untreated, non-diarrheal Reiter's syndrome and associated urethritis (1). Patients who are HLA-B27 positive have an increased risk of Reiter's syndrome.

Chlamydia proctitis may be caused by the genital serovars D through K or the LGV serovars L_2 in patients who report anal-genital contact. The D through K strains tend to cause an asymptomatic or mild syndrome with rectal pain, discharge, tenesmus and bleeding, whereas the LGV strains are associated with more severe ulcerative proctitis or proctocolitis.

Diagnosis

The diagnosis of *Chlamydia* genital infections must first be suspected by a complete history and physical exam. Routine laboratory tests are helpful but are non-specific. A Gram's stain of cervical discharge may show neutrophils, and urinalysis in either sex may show pyuria with the routine culture being negative.

The complete blood count is usually normal if only cervicitis or urethritis is present, whereas it may be elevated in PID. In perihepatitis, the liver enzymes may be elevated. In a sexually active woman, a measurement of β subunit of human chorionic gonadotropin (beta HCG test) should be done if ectopic pregnancy needs to be excluded.

The gold standard of confirming the diagnosis of *C. trachomatis* is the tissue culture. The specimen must be collected on a Dacron swab (not a cotton-tipped swab) after the cervical mucus has been removed (11). The sample must be transported on ice within 24 hours. Growth in cell culture is followed by specific fluorescent staining for the organism. Cell culture of *Chlamydia* may be of greatest value in screening low-risk populations (13).

Difficulties inherent in tissue culture techniques have encouraged the development of indirect assays to diagnose *Chlamydia* infections (13). The two most widely used assays at present are the direct immunofluorescent assay (DFA) and the enzyme-linked immunoassay (ELISA). Advantages of these techniques over standard culture techniques to detect *Chlamydia* antigen include easier collection of the specimen and transport, decreased technical difficulty, faster results, and reduced cost. A disadvantage of the indirect assays, however, includes reduced sensitivity, which is especially important when the test is used to screen asymptomatic women. Compared with culture, the sensitivities of the indirect assays have ranged from 75%-90%; specificities are about 95%. In high-risk populations, the indirect assays appear to have high sensitivity; however, when used in low-prevalence settings such as routine gynecology office practice, the sensitivity will be lower (11,13).

Endocervical specimen quality also affects the incidence of true positive and false positive ELISA tests (14). An alternative method for diagnosis includes initial screening with an enzyme immunoassay followed by a direct fluorescent antibody (DFA) test on specimens with an equivocal result on screening (15). This strategy has been shown to increase sensitivity, retain specificity, and may be feasible for laboratories without tissue culture capabilities.

It is recommended that tissue culture be used to confirm the diagnosis of *C. trachomatis* genital infection when available and affordable. When screening high prevalence populations, the indirect assays are most useful. Screening for *Chlamydia* infections using one of the diagnostic tests should include all women with suspected mucopurulent cervicitis, endometritis, PID, acute urethritis, or acute proctitis, as well as women whose male partners have urethritis. Women in these categories should be treated empirically without

Table 3. Treatment of *Chlamydia* Genital Infections*

Uncomplicated Urethral, Endocervical, or Rectal *C. trachomatis* Infections

Recommended Regimen:
Doxycycline 100 mgs. orally twice a day for seven days
or
Tetracycline 500 mgs. orally four times a day for seven days

Alternative Regimen:
Erythromycin base 500 mgs. orally four times a day or equivalent salt for seven days
or
Ofloxacin 300 mgs. orally twice a day for seven days
or
Azithromycin 1 gm. orally once

Infection in Pregnancy

Recommended Regimen:
Erythromycin base 500 mgs. orally four times a day for seven days (estolate form is contraindicated in pregnancy)

Alternative Regimen:
Erythromycin base 250 mgs. orally four times a day for 14 days
or
Erythromycin ethylsuccinate 800 mgs. orally four times a day for seven days
or
Erythromycin ethylsuccinate 400 mgs. orally four times a day for 14 days

Alternative Regimen If Erythromycin Cannot Be Tolerated:
Amoxicillin 500 mgs. orally three times a day for seven days (limited data available)

* Adapted from references 16 and 18

awaiting test results; however, a positive test result is important for management of the patient and sexual partners (13).

Diagnostic tests for *Chlamydia* are strongly encouraged by the Centers for Disease Control for screening asymptomatic high-risk women (16). Such groups include all women attending clinics for treating sexually-transmitted diseases or other clinics where the prevalence of infection is high, and others at high risk including adolescents and those with new or multiple sex partners (13). All pregnant women should be considered for screening. A greater number of *Chlamydia* infections can be diagnosed clinically in men than in women. Men also have fewer serious complications from the infection compared to women. Therefore, screening efforts should be directed mainly at women. If resources are available, diagnostic tests for *Chlamydia* may be useful in men who are at high risk for these genital infections (13).

Treatment

In clinical settings where testing for *Chlamydia* is not available or routine, empiric treatment should be given to patients with compatible clinical syndromes. In addition, sexual partners of patients with proven or suspected *Chlamydia* should be treated presumptively.

Cervicitis or urethritis should be treated with doxycycline 100 mgs. po b.i.d. for 7-10 days, tetracycline 500 mgs. po q.i.d. for 7-10 days, or erythromycin 500 mgs. po q.i.d. for 7-10 days (16). Erythromycin should be used if there is any possibility of pregnancy (Table 3). Ofloxacin, one of the new fluoroquinolones, has also been shown to be effective at a dose of 300 mgs. po b.i.d. for 7-10 days, but is not yet standard therapy. Azithromycin, a new macrolide, has also shown efficacy in *C. trachomatis* infection and may allow a shorter course of therapy (17). Treatment failures with the standard regimens have not been shown to be secondary to resistance of the organism, but rather to non-compliance or re-infections. The treatment of PID should always include a regimen of doxycycline, tetracycline, or erythromycin for 10-14 days, in addition to the other standard therapy directed against the other pathogens of PID (16,18).

Proper treatment and follow-up of patients with *Chlamydia* is important to prevent sequelae as well as spread to sexual partners. All patients with *C. trachomatis* genital infections should be screened for other sexually transmitted diseases (STD), including syphilis and gonorrhea. A human immunodeficiency virus (HIV) antibody test should be offered to every patient with suspected or confirmed *Chlamydia* infection. Due to the fact that all sexually-transmitted diseases are inevitably linked, efforts to control *Chlamydia* infection are essential to help control all STD, including HIV.

Acknowledgement

We would like to thank Mrs. Toni Burbridge for her help in preparing this manuscript.

References

1. Bowie WR, Holmes KK. *Chlamydia trachomatis*. In: Mandell GL, Douglas RG, Bennett E, editors. Principles and practice of infectious diseases. 3rd edition. New York: Churchill Livingston; 1990;1426-40.
2. Gordon FB, Quan AL. Isolation of the trachoma agent in the cell culture. Proc Soc Exp Biol Med 1965;354:354-9.
3. Wang SP, Grayston JT. Immunologic relationship between genital TRIC, lymphogranuloma venereum, and related organisms in a new microtiter indirect immunofluorescence test. Am J Ophthalmol 1970;70:367-74.
4. Setness PA. Chlamydial infections. Gaining control of a growing epidemic. Postgrad Med 1989;85:109-13.
5. Kuo CC. Immediate cytotoxicity of *Chlamydia trachomatis* for mouse peritoneal macrophages. Infect Immun 1978;20:613-8.
6. Taverne J, Blyth WA, Ballard RC. Interactions of TRIC agents with macrophages: effects on lysosomal enzymes of the cell. J Hyg 1974;72:297-309.
7. Handsfield HH, Jasman LL, Roberts PL, et al. Criteria for selective screening for *Chlamydia trachomatis*. Infect Immun 1982;37:422-6.
8. Centers for Disease Control. *Chlamydia trachomatis* infections: policy guidelines for prevention and control. MMWR 1985;34 Suppl 3:53-74.
9. Washington AE, Johnson RE, Sanders LL Jr. *Chlamydia trachomatis* infections in the United States: what are they costing us? JAMA 1987;257:2070-2.
10. Handsfield HH, Jasman LL, Roberts PL, et al. Criteria for selective screening for *Chlamydia trachomatis* infection in women attending family planning clinics. JAMA 1986; 255:1730-4.
11. Freund KM. Chlamydia disease in women. Hospital Practice 1992;27:175-86.
12. Cates W, Hinman AR. Sexually transmitted diseases in the 1990s. N Engl J Med 1991; 325:1368-70.
13. Stamm WE. Diagnosis of *Chlamydia trachomatis* genitourinary infections. Ann Intern Med 1988;108:710-7.
14. Kellogg JA, Seiple JW, Klinedinst JL, Levisky JS. Impact of endocervical specimen quality on apparent prevalence of *Chlamydia trachomatis* infections diagnosed using an enzyme-linked immunosorbent assay method. Arch Pathol Lab Med 1991;115: 1223-7.
15. Schwebke J, Stamm WE, Handsfield HH. Use of sequential enzyme immunoassay and direct fluorescent antibody tests for detection of *Chlamydia trachomatis* infections in women. J Clin Micro 1990;28: 2473-6.
16. Centers for Disease Control. 1989 Sexually transmitted diseases treatment guidelines. MMWR 1989;38 Supple 8:27-33.
17. Martin DH, Mroczkowski TF, Dalu ZA, et al. A controlled trial of a single dose of azithromycin for the treatment of chlamydial urethritis and cervicitis. N Engl J Med 1992;327:921-5.
18. Drugs for sexually transmitted diseases. Med Lett 1991;33:119-24.

WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF CONTINUING MEDICAL EDUCATION

19th Annual Hal Wanger Family Medicine Conference

September 30, October 1 & 2, 1993

Health Sciences Main Auditorium
Robert C. Byrd Health Sciences Center
Morgantown, West Virginia

Registration Form

Registration is recommended by September 10, 1993

Name _____ Degree _____
(MD, PhD, etc.)

Address _____

City _____ State _____ Zip _____ County _____

Daytime Telephone ( ) _____ Home Telephone ( ) _____

Social Security Number _____ - _____ - _____ Affiliation _____

Specialty _____ Subspecialty _____

Please specify the exact name to be printed on your certificate. Print or type name.

_____

Course Fees*

	Price	Total
Thursday, Friday and Saturday	**$195.00**	$
Thursday and Friday	**$165.00**	$
☐ Thursday only ☐ Friday only	**$100.00**	$
Saturday Only	**$ 90.00**	$
Football Tickets (limit 4) WVU vs. Virginia Tech	**$ 20.00**	$
# of guests attending "Mountaineer Physicians" Pre-game Tent	# _____	no charge
	Total	$

**Course fees include conference materials, meals, and Saturday parking.*

Credit Card payment: Please charge my ☐Visa ☐MasterCard Card number _____

Expiration Date _____ Authorization Signature _____

Make check payable to ***WVU Foundation*** and return with this form to:

Office of Continuing Medical Education
1250 Health Sciences South
PO Box 9080
Morgantown, WV 26506-9080

Special Requirements

If you require access and parking for the handicapped, please so indicate:

_____

President's Page

Robert P. Pulliam M.D.

Medical system failure?

Is our health care system a failure? Does our health care system need reform?

Reform is defined by Webster's as amendment of what is defective, vicious, corrupt, or depraved. Is our health care system one of these? I think not, but maybe the bias is in the eye of the beholder. In evaluating the U.S. health care system, I feel it is important to consider several points.

First of all, our medical care is envied around the world. Political leaders and wealthy individuals from other countries frequently seek care here because they understand quality. Is this evidence of medical system failure?

Modern trauma centers now save over 80% of the victims arriving at their doors. Twenty-five years ago, the survival rate was 25%. Is this evidence of medical system failure?

Maternal mortality rates have been drastically reduced in the last decade as have fetal death rates, neonatal death rates and infant death rates. Is this evidence of medical system failure?

Hopefully, you realize as I do that these facts and statistics are not evidence of failure, but of something else entirely. Consider the following flip sides of the points I have mentioned.

Government has failed to enforce auto safety standards and keep drunk drivers off the road. Is this evidence of medical system failure?

Government has failed to stem drug trafficking, especially in our inner cities. Is this evidence of medical system failure?

Government has failed to educate parents, children, and community leaders when 3,000 adolescent females become pregnant in the United States every day. Is this evidence of medical system failure?

The Clinton administration has promised to reform "a failed medical system." The real question is "WHAT has failed?" If we, as physicians, become convinced by the high-pitched rhetoric that our medical system has failed, the system will be replaced by one with the efficiency of the U.S. Postal Service and the charm of the IRS.

What we need is not reform, but improvement! Each of us recognizes quality and imperfections. We need to correct the imperfections, not reform a success.

Robert P. Pulliam, M.D.

No reality except in action

Editor's Note: *This month we are pleased to publish an editorial which was submitted to us by John Overington, a member of the West Virginia House of Delegates. Delegate Overington is a Republican who represents the 54th District.*

Doctors in West Virginia are faced with a choice: Be driven out of the state by politicians listening to other voices and who have created the most inhospitable medical environment in the nation, or get active in the political process to fight for tort reform and policy-making input in health care decisions.

As a long-time supporter of the interests of the medical profession -- not because I am trying to vote doctors special advantages or privileges, but because they need a fair and level playing field to operate -- I have noticed how little doctors are involved in the political process. Personally, I have observed that outside of one local doctor, I get relatively small and few donations from health care professionals. My opponents in the past five elections would tend to get $500 to $1,000 donations from LAWPAC, as well as other sizable donations from individual lawyers.

It is obvious other legislators in their own election races have noticed this phenomena, and many have moderated their positions to reflect this. Practically put, your next opponent is much more apt to be a lawyer than a doctor, and lawyers are much more generous financially to their political friends.

During the battle over S.B. 576 several years ago, I noticed a naive idealism among doctors. They felt that elected officials would do what was in the best interest of health care and health care professionals. Doctors seemed to act as though all they had to do was make their case be known and the right course would be obvious and followed. The loss by default on S.B. 576 opened up the eyes of some doctors to the reality that competing special interest groups were not necessarily looking out for the public's good, but were instead interested in gaining special privileges and benefits.

Since then, several doctors have run for office and three are now serving in the Legislature. Even though Delegate Dr. Robert Pulliam presented medicine's case in an intelligent, articulate and charming manner on the House floor, doctors still found that the outcome of the votes was not affected. The leadership of the Legislature and the legal special interest groups had a lock on the numbers they needed for their positions to prevail.

West Virginia doctors are thus left with the choice I have already spelled out in the first paragraph. If they want to practice in an environment with a fair and level playing field, they will have to fight for this in the political arena. The legislative process is the clash of competing interests. Not aggressively competing means loss by default. Whether the system should be that way is not the question. In West Virginia it is that way.

This reality was pointed out by Dr. Pulliam in his message last month in the *West Virginia Medical Journal* when he presented the figures which showed that LAWPAC's donations outnumbered WESPAC's by a 10-1 margin. This was very apparent during the 1993 legislative session because on the 10 to 15 votes affecting the livelihood of doctors and of health care professionals in general, doctors lost every vote. These included collateral source evidence rule changes, capping attorney fees and other tort reform provisions, as well as taxing the health care community, and taxing tobacco products instead of doctors. The only question is how doctors will respond to these defeats. Ignoring them will not cause them to go away or get better.

The good news is that the bad news has gotten so bad that doctors are getting the message that if they want to stay in business in West Virginia, they must pay more attention to the political environment. Even though doctors are very busy people, they must take the time to learn and follow the political process. They must get active in electing officials who, if not sympathetic to their perspective, are at least not out to get them.

This is not to criticize other competing special interest groups. Whether it be unions wanting socialized medicine or lawyers wanting to represent clients, they are simply exercising the freedoms this great country affords us all -- the right to participate in the political process. This is to point out that all sides are not participating equally and the results show it.

Let me close with three quotes; the first two are my own from observing the political process and the third is from Jean Paul Sartre. "Being right doesn't mean you will prevail." "Perception is the reality that politics is based on." "There is no reality except in action."

Delegate John Overington - R
Martinsburg

Our Readers Speak

Carotid endarterectomy article needs clarification

After reading the article, *"Indications for Carotid Endarterectomy,"* by Howard H. Kaufman, M.D., and Joseph L. Voelker, M.D., which appeared in the March issue of the *West Virginia Medical Journal*, I feel strongly that certain points should be clarified so readers will have a better understanding of the indications for carotid endarterectomy, particularly for asymptomatic carotid disease.

I agree totally with the conclusion of the authors in regards to patients with symptomatic carotid artery disease. Therefore, my comments will be confined primarily to patients with asymptomatic carotid artery stenosis.

The literature is crowded with many retrospective trials regarding the pros and cons of advocating this surgery for asymptomatic patients as indicated by Dr. Kaufman and Dr. Voelker in their references. However, their conclusion that patients with asymptomatic disease should not be offered surgery and should be treated with aspirin, cannot be accepted as such by the majority of the most respected vascular surgeons in this country. This is based on facts which I will elaborate on and which can also be referred to in an editorial in the *Journal of Vascular Surgery* by Jesse E. Thompson, M.D. (1).

I share Dr. Thompson's opinion and I feel that some of the most important parts of that editorial should be shared with the readers of the *West Virginia Medical Journal*. Dr. Thompson, who is on the faculty at the Southwestern Medical School in Dallas, is one of the legends and early pioneers of carotid endarterectomy, and is known for his worldwide publication on this subject.

Dr. Kaufman's and Dr. Voelker's discussion of the VA Cooperative Study, which was published by Dr. Robert Hobson (2), must be clarified to be fair to the study and to Dr. Hobson, who happens to be one of the most respected professors of vascular surgery in this country. As the authors indicated, Dr. Hobson's study reported the result of the multi-center VA randomized trial designed to study the effect of carotid endarterectomy on the combined incidence of outcome events including TIA and stroke patients with asymptomatic carotid stenosis. All patients who had asymptomatic carotid stenosis were shown by arteriography to have 50% or more reduction in the diameter of the artery. The combined incidence with all ipsilateral neurological outcome events (TIA and CVA) was 8% for the surgical group and 20.6% for the medical group ($P < 0.001$). The incidence of ipsilateral stroke alone was reported to be 4.7% for the surgical group and 9.4% for the medical group ($P < 0.06$). The conclusion reached was that carotid endarterectomy reduced a total incidence of ipsilateral neurological events in this selected group of male patients with asymptomatic carotid stenosis.

The first item in this study which I feel needs to be commented on is the fact that all patients were high-risk veterans in which heart disease is very common. This is reflected in the operative mortality and stroke morbidity figures. The operative mortality was 1.9% and the stroke morbidity was 2.4%, creating a combined mortality and morbidity figure of 4.3%. This is higher than figures reported in the literature. In a recent survey of 11 series comprising 2,183 asymptomatic patients, the average operative mortality was 0.7% and permanent stroke rate was 1.25% for a combined figure of 1.95% (3). In settings other than VA hospitals, surgical risks are probably fewer with lower operative mortality and morbidity rates.

Secondly, in this study all arteriographic complications (stroke rate of 0.4%) were assigned to the surgical group. This statistical quirk penalizes the surgical results and does not seem fair. These strokes should either be excluded or assigned equally to the two groups, medical and surgical. If one excludes these strokes because of arteriography and recalculates the data, the combined event outcome results are 6.6% for surgical cases and 20.6% for the medical group, more significant than a $P < 0.001$. Likewise, if one excludes these strokes and recalculates the data for strokes alone, the results show 3.3% for the surgical group and 9.4% for the medical group, more significant than a $P < 0.06$ or 65% reduction in the expected rate of stroke had these patients not received endarterectomy. Therefore, the results of the study are actually more favorable towards surgery than those reported in the article.

A third point of the study I must mention is that 32% of the patients gave a history of prior cerebral ischemic events appropriate to contralateral stenosis, 80% TIAs and 20% strokes, with 80% of these patients having had previous carotid endarterectomy equally distributed between the medical and the surgical groups. Thus, 32% of the patients were not truly asymptomatic, but actually had been symptomatic. This obviously influences the outcome of the trial, favoring the medical group.

Prior carotid endarterectomy protects against subsequent stroke, with the incidence of stroke being much lower than expected during follow-up in the presence of the contralateral stenosis. In four reported series of this kind (ipsilateral stenosis operated on for symptoms with contralateral asymptomatic stenosis following), the incidence of TIAs range from 13.7% to 16.7%, whereas the incidence of stroke varied only from 2.4% to 4.5% (4,5,6). Among the truly asymptomatic patients in Dr. Hobson's series (68% of the trial sample), the incidence of neurological events was 7.6% for the surgical group and 19.2% for the medical group ($P < 0.004$), for a reduction of 60% in the incidence of postoperative neurological events to be expected in these patients if they had undergone the operation.

A fourth important point which must be noticed in this study is that

one-half of the outcome events in the medical group were strokes, all occurring without premonitory TIA. Thus, waiting for a TIA to occur before recommending arteriography and surgery in these patients gives a false sense of security to patients and doctors.

The general belief is that carotid stenoses of severe degree are greater risk factors for strokes than those of lesser degree. Most of the recently reported non-randomized clinical studies on asymptomatic stenoses have arbitrarily used 70% or a greater diameter reduction as a degree of stenosis required as an indication for operation (3). In the one study of asymptomatic carotid stenosis, when stenosis progressed in the carotid lesion to 80% or more, stenosis resulted in the occurrence of ischemic symptoms or total occlusion in 35% of patients at six months and 46% at 12 months (7). Therefore, since the VA study included patients above 50% equal to or above 50% stenosis, its data cannot be uniformly accepted for stenosis of much higher degree.

Finally, all operative deaths and most long-term deaths were from coronary artery disease and other non-stroke medical causes, which is to be expected in these VA high-risk patients. Although in this VA trial the long-term results from carotid endarterectomy as prevention alone are not as significant statistically as are the results of combined neurological events (TIAs and stroke) which are highly significant in favor of surgery, the stroke alone data does favor the surgical group also. If one is to justify operation on these patients with asymptomatic carotid stenosis, indication must be highly selected. Multiple risk factors, especially cardiac, should be minimal. Angiography should be performed by skillful individuals and the operation must be done by well-trained surgeons. Under these circumstances, operative mortality and morbidity are low and acceptable.

Therefore, I cannot agree with Dr. Kaufman and Dr. Voelker that at this moment patients with asymptomatic diseases should be left alone or given aspirin, particularly knowing the fact that there are several articles indicating that aspirin might be a contributing factor to carotid plaque hemorrhage which might produce symptoms in the future (8,9). There is no well controlled study to indicate aspirin is beneficial for asymptomatic carotid artery stenosis.

My present recommendation for asymptomatic carotid artery stenosis, which is shared by many well respected professors in vascular surgery in this country, is that carotid endarterectomy can be done with minimal morbidity and mortality for asymptomatic stenosis (stroke < 3%), and is a beneficial operation for patients with asymptomatic carotid stenosis of at least 70% and above in patients who are good risks with minimal cardiac morbidity and mortality. This view can be modified waiting for the results of the ACAS study (Asymptomatic Carotid Artery Study), which will be published soon.

Ali F. AbuRahma, M.D.
Professor of Surgery
Chief, Vascular Section
Medical Director, Vascular Laboratory
WVU Health Sciences Center
Charleston

References

1. Thompson JE. Carotid endarterectomy for asymptomatic stenosis: Benefits confirmed by randomized trial. J Vasc Surg 1993;17:798-800.
2. Hobson RW II, Weiss DG, Fields WS, et al. Efficacy of carotid endarterectomy for asymptomatic carotid stenosis. N Engl J Med 1993;328:221-7.
3. Thompson JE. Carotid endarterectomy for asymptomatic carotid stenosis: an update. J Vasc Surg 1991:13:669-76.
4. Johnson N, Burnham SJ, Flanigan DP, et al. Carotid endarterectomy: a follow-up study of the contralateral non-operated carotid artery. Ann Surg 1978;188:748-52.
5. Podore PC, DeWeese JA, May AG, Rob CG. The asymptomatic contralateral carotid artery stenosis: a five-year follow-up study following carotid endarterectomy. Surgery 1980;88:748-52.
6. Durward OJ, Ferguson GG, Barr HWK. The natural history of asymptomatic carotid bifurcation plaques. Stroke 1982;13:459-64.
7. Roederer GO, Langlois YE, Jager KA, et al. The natural history of carotid arterial disease in asymptomatic patients with cervical bruits. Stroke 1984;15:605-13.
8. AbuRahma AF, Boland JP, Robinson P, Decanio R. Antiplatelet therapy and carotid plaque hemorrhage and its clinical implications. J Cardiovasc Surg 1990;31:66-70.
9. Ernst RL, Ammar AD, Lin JJ, et al. The effect of antiplatelet therapy on the incidence of carotid plaque hemorrhage. Stroke 1986;17:540-1.

Joseph G. Feghali, MD

Glaucoma Consultation and Surgery

Member of the American Glaucoma Society

- Specializes in pediatric and adult glaucoma
- Computerized optic nerve tomography: a quantitative scanning laser method to assess optic nerve tissue damage from glaucoma
- Glaucoma drainage implants: an established new surgical procedure for refractory and high-risk glaucoma cases

Joseph G. Feghali, MD - 2000 Hampton Center, Suite D - Morgantown, WV 26505
For appointments, call: (304) 599-6627 or (800) 333-6627

In My Opinion

Difficult recovery from addiction made easier by support of my peers

As a recovering physician, I am just now to the point of being able to discuss my journey through addiction with my physician friends and peers. This is probably the most significant event that has occurred in my life and I hope that by sharing my struggles with others, that someone with a similar problem may be spared the pain and agony that I have gone through over the past two years.

We, as physicians, know addiction is a disease and it has been considered so since the 1930s by the American Medical Association. Unfortunately, though, a dependence on a substance or activity condemned by society as illegal or immoral leads the addicted person to act in anti-social ways; therefore, the addicted person will gravitate to anti-social behavior in order to avoid from conflicting with society's ideals and condemnation.

I am really not sure why I developed a drug addiction and that really does not matter today because recovery teaches me to focus on the solution and not to dwell on the problem. However, I do know that addiction isolated me from people, places and things outside of my world of using and finding ways and means to continue my addiction. I cut myself off from outside interests as my illness progressed and I lived in fear and suspicion of the people that I depended on for my needs. As a consequence, my addiction touched every area of my life and things became very alien to me. My world shrank and isolation was its goal. To me this is a true nature of the disorder of addiction -- isolation and alienation.

My recovery began the day I surrendered my license to practice medicine due to my illness and started treatment. I can remember during that time feeling a need for some kind of direction from my peers as I felt very uncertain as to the process to regain my ability to practice my profession once again. At that time, I was given excellent direction from my friends in recovery on how to deal with my addiction; however, I felt totally alone when it came to dealing with the problems facing me as a result of the forfeiture of my license to practice medicine.

These types of problems are what I tend to call the "domino effect" because when the insurance carriers, malpractice carriers and other agencies were informed of the forfeiture, the issues that arose seemed endless to me at the time.

Nevertheless, I was able to weather the storm and continue my recovery and eventually my license was re-instated on a probationary basis. One thing that I did learn during this period was that it was very beneficial to be a member of my local medical society and the WVSMA because they were able to aid me in returning to the practice of medicine. I can remember many times over the past several years that I had strongly considered not joining the local, state and national medical societies due to the fact that I felt they would not benefit me. However, I would strongly suggest that any physician thinking about not joining, reconsider because I am eternally grateful to my physician sponsor and the Raleigh County Medical Society for supporting me during this time.

One thing I have learned during this journey is that the practice of medicine is not my life, but it is how I underwrite my life, and I had to learn this the hard way. Concerning my recovery, it appears to me that the most successful means of overcoming serious physical addiction is complete abstinence supported by participation in a 12-step program. The basis for my recovery in this program is unashamedly spiritual and included admitting powerlessness over my addiction, seeking the guidance of a Higher Power as I understand it, working through a serious self evaluation, making amends to those injured by my addiction, and reaching out to others who are still suffering with their addiction.

For me, this journey has not been easy, but it has made things much better within my heart, and I believe I will be dealing with my addiction for the rest of my life. Hopefully, with the support of my friends in recovery and my peers in the medical profession I will continue to recover.

Richard C. Wisman, M.D.
Beckley

Successful Money Management Seminars

FOR WEST VIRGINIA STATE MEDICAL ASSOCIATION MEMBERS AND THEIR SPOUSES

- Huntington September 8, September 15 and September 22
- Beckley October 13, October 20 and October 27
- Parkersburg November 3, November 10 and November 17

Comprehensive Seminar Agenda

SESSION 1

Your Foundation for Financial Independence
- Why Everyone Needs Financial Planning
- Six Main Objectives of Financial Planning
- Reallocating Your Income
- The Success Triangle™
- Six Main Reasons People Fail Financially
- Take Advantage of Your Lifetime Earning Power
- Become Financially Independent;
- The Eighth Wonder of the World—Compound Interest
- The Effects of Inflation
- Your Tax Bracket—How it Affects Your Financial Plan

Putting Your Dollars to Work—Part I
- Importance of Cash Reserves
- Types of Cash Reserves
- Restricted Cash Reserves
- Tax-Deferred Fixed Annuities
- Fixed-Income Securities
  - Government Securities
  - Corporate Bonds
  - Municipal Bonds

Putting Your Dollars to Work—Part II
- Equity Investments
  - Common Stock
  - Preferred Stock
  - Reading the Stock Tables
  - Risk Factors
  - Managed Accounts
- Ten Steps to Financial Success
  - Your Personal Financial Plan—The Key to Your Success

SESSION 2

Putting Your Dollars to Work—Part II
- Mutual Funds
  - Families of Funds
  - Types of Funds
  - Dollar Cost Averaging
  - Selecting Specific Funds
  - Asset Allocation
- Guaranteed Versus Equity Investments
- Limited Partnerships
- Tangible Assets
- College Funding

Retirement Planning
- Social Security

401(k) Plans

403(b) Tax-Sheltered Annuities

Simplified Employee Pensions (SEP-IRA)

Individual Retirement Accounts (IRA)

SESSION 3

Retirement Planning (continued)
- Tax-Deferred Variable Annuities
- Systematic Withdrawal Programs
- Risk Management
- Insuring Your Most Valuable Asset
- Long-Term Health Care
- Life Insurance
- Enhancing Your Pension Benefits with Life Insurance
- Estate Planning
  - Objectives of Estate Planning
  - Probate-Should it be avoided?
  - Living Revocable Trusts

SESSION 4

Optional

Everyone attending this seminar is entitled to a personal financial planning consultation after the conclusion of Session Three. This is your opportunity to ask specific personal questions regarding your financial future at no additional cost.

ENROLLMENT FORM

(Member's Name) _____ (Spouse's Name) _____

(Mailing Address) _____

(Telephone Number) _____ (Seminar Location I Plan To Attend) _____

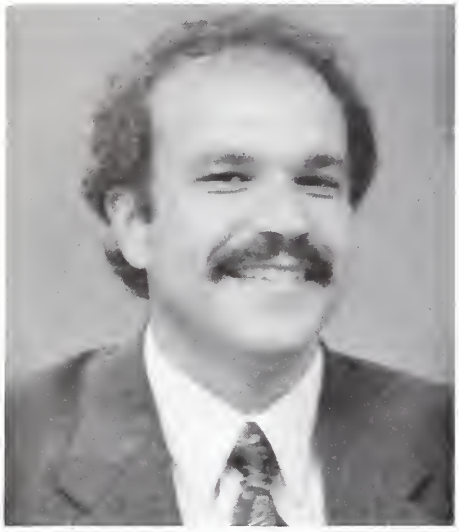
Call (304) 925-0342 for more information.

Registration Fee: $250 (member) $125 (spouse)

Bonus for early registration: If registration is confirmed 10 days prior to the seminar, the spousal fee will be waived.

* Make check payable to West Virginia State Medical Association
* Mail enrollment form and fees to: West Virginia State Medical Association
  P. O. Box 4106
  Charleston, WV 25364

Comerci to be installed as WVSMA president



Comerci

Wheeling family practitioner James L. Comerci, M.D., will take the WVSMA presidential oath of office on Saturday, August 21, during the Second Session of the House of Delegates at the WVSMA's 126th Annual Meeting at The Greenbrier.

Born in Beckley, Dr. Comerci received both his B.A. degree in chemistry and his doctor of medicine degree from West Virginia University. He completed his residency in family medicine at Wheeling Hospital from 1980-83 and then went into private practice in Wheeling.

A member of the WVSMA since 1984, Dr. Comerci began serving on Council in 1987 and was named vice president in 1991, then president-elect in 1992. In addition to his positions on Council and the Executive Committee, Dr. Comerci served as program chairman of the WVSMA's Annual Meeting in 1990, and has been a member of the Legislative Committee since 1991. Dr. Comerci is also a member of the AMA and the Ohio County Medical Society, of which he was president in 1990. He is board certified by the American Board of Family Practice.

A clinical assistant professor of family medicine at WVU, Dr. Comerci is also very active in the Wheeling area medical community. He is a board member, a volunteer physician and a member of the Prenatal Care Committee at Wheeling Health Right; is a part-time team physician at Bethany College; and serves on the Utilization Review Committee at Good Shepherd Nursing Home.

Dr. Comerci and his wife, Lynn, have two daughters, Michele and Jennifer.

Special Thanks ! ! !

The WVSMA staff would like to recognize the members of this year's Annual Meeting Program Committee for the effort put forth by each individual. The time and initiative taken by these members goes beyond expectations and is sincerely appreciated by the staff and all those who have the opportunity to participate in the Annual Meeting:

Lee L. Neilan, MD, Chairman
Constantino Y. Amores, MD
Thomas H. Chang, MD
James L. Comerci, MD
C. Richard Daniel, MD
Chinmay K. Datta, MD
Erlinda De La Pena, MD
David A. Denning, MD
Ahmed D. Faheem, MD
Robert A. Gustafson, MD
Michael J. Lewis, MD
Maurice A. Mufson, MD
Edward Pinney, MD
Pacita Salon, WVSMAA President
Stephen L. Sebert, MD
Mabel M. Stevenson, MD

Ex-Officio Members

David Bailey, MBA, CME - Marshall University, Huntington
Kari Long, CME - West Virginia University, Morgantown
Robin Rector, CME - West Virginia University, Charleston

Dance to feature "A Spectrum of Music;" lessons again offered

By popular request, dance lessons and a dance will again be featured at this year's WVSMA and WVSMAA Annual Meeting at The Greenbrier.

Jerry and Sherry Rose of Beckley, who were the dance instructors last year, will conduct a variety of lessons on Thursday, August 19 from 9 p.m. to 11 p.m. in Colonial Hall at The Greenbrier. The dance will then be held on Friday, August 20 from 9 p.m. to 1 a.m. in the Colonial Hall and is entitled "A Spectrum of Music." The band will be The Masters, who will play a wide selection of music ranging from Big Band to country to Top 40.

Tickets for the dance lessons and the dance are $25 per couple for each event. They can be purchased at the Registration Desk, at the lessons and the dance, or by phoning the WVSMA office at 925-0342.

WVSMA Annual Meeting Highlights

Wednesday, August 18

8 a.m.	Executive Committee Breakfast
9 a.m. - 11:30 a.m.	Executive Committee Meeting
11:30 a.m.	Council/Executive Committee Luncheon
1:30 p.m. - 4:30 p.m.	WVSMA Council Meeting
1:30 p.m. - 4:30 p.m.	Registration/Exhibit Visitation
6:30 p.m. - 7:30 p.m.	WVSMA Presidential Reception

Thursday, August 19

7:30 a.m. - 2 p.m.	Registration/Exhibit Visitation
8 a.m. - noon	Scientific Session *"Doctors View Today's Dysfunctional American Family"* David Z. Morgan, MD - Morgantown George Comerci, MD - Tucson, Ariz. Michael Thase, MD - Pittsburgh Michael A. Kelly, MD - Daniels Glen Aukerman, MD - Morgantown
Noon - 1:30 p.m.	Lunch & Learn *(featuring Ronald Alexander, JD, Cleveland, Ohio, and Visiting Dignitaries)*
1:30 p.m.	Committee on Resolutions *(open session)*
2 p.m.	Tournaments
4 p.m.	1994 Annual Program Committee Meeting
6:30 p.m. - 7:30 p.m.	Reception *(sponsored by CNA/McDonough Caperton Insurance Group)*
9 p.m. - 11 p.m.	Dance Lessons *(featuring Jerry & Sherry Rose)*

Friday, August 20

7:30 a.m. - 8:30 a.m.	WVSMA Surgery Section Breakfast
8 a.m. - 4 p.m.	Registration/Exhibit Visitation
8 a.m. - 12:30 p.m.	WVSMA Dermatology Section Meeting
8:30 a.m. - noon	First Session/House of Delegates E. B. Flink Address *(presented by George Comerci, MD, Tucson, Ariz.)* T. L. Harris Address *(presented by John G. Hunter, MD, Atlanta)* Business Meeting
11 a.m.- 3 p.m.	WV Medical Institute's Board of Trustees Business Meeting
Noon	Lunch and Learn *(featuring Visiting Dignitaries)*
Noon	WV Academy of Otolaryngology Meeting
Noon	WVSMA Cancer Committee Meeting
Noon	WV Chapter of the American Academy of Pediatrics Meeting
Noon	WV Psychiatric Association Meeting
12:30 p.m.	WVSMA Publication Committee Meeting
1 p.m.	WV Orthopedic Society Meeting
4 p.m.	Resolutions Committee Meeting
6 p.m. - 7 p.m.	Reception *(hosted by the West Virginia University and Marshall University Schools of Medicine, and the Medical College of Virginia Alumni Association)*
9 p.m. - 1 a.m.	Dance "Spectrum of Music" *(informal attire)*

Saturday, August 21

7 a.m. - 8 a.m.	Ohio County Medical Society Meeting
7:30 a.m. - 9:30 a.m.	Delegate Registration
7:30 a.m. - 8:30 a.m.	Kanawha Medical Society Meeting
7:30 a.m. - 9 a.m.	Young Physicians Section Meeting
7:30 a.m. - 9:30 a.m.	WV Radiological Society Meeting
8 a.m. - 12:30 p.m.	WVSMA Dermatology Section Meeting
8 a.m.	Second Session/House of Delegates AMA President's Address *(presented by Joseph Painter, MD)*
Noon - 1:30 p.m.	Luncheon Honoring WV Component Society and Specialty Society Presidents, Past Presidents, 50-Year Graduates and Visiting State Presidents
Noon - 1 p.m.	WVSMA Sports Medicine Section Meeting
1:30 p.m.	Second Session/House of Delegates *(continued)*
4 p.m. - 5 p.m.	Reception Honoring 1993-94 WVSMA and WVSMAA Officers *(time dependent upon adjournment of House of Delegates' Session)*

AMAA, SMAA leaders to headline program

Hanson

Dunn

Salon

Scaring

Mary Hanson, president of the American Medical Association Alliance, and Ebba Dunn, president of the Southern Medical Auxiliary, are two of the featured speakers at the WVSMA Auxiliary's 69th Annual Meeting at The Greenbrier, August 18-21.

Mrs. Hanson will address the WVSMAA members on Friday morning, August 20 during the Second Session of the House of Delegates, and Mrs. Dunn will make her presentation on Thursday morning, August 19 during the First Session of the House of Delegates. In addition to the speeches by these two leaders, another special highlight of this year's meeting will be a session entitled "Active Parenting," which will be conducted by Novella Woodrum, counselor for The Family Center in Beckley.

Pacita Salon, president of the WVSMAA, will preside over the business meetings at the convention, and Mrs. Hanson will install Carole Scaring as the new president at the end of the Second Session of the House of Delegates. During the convention, the WVSMA Auxiliary's name will officially become the WVSMA Alliance in accordance with a change in the bylaws which will take effect on Friday, August 20 with the installation of the new officers.

AMAA, SMA leaders profiled

Mrs. Hanson of Colorado Springs, Colo., was installed as president of the AMA Alliance at the 1993 Annual Meeting in June in Chicago.

Active in the organization for many years, Mrs. Hanson previously served at the national level as secretary, treasurer, vice president, director, member and chairman of the Finance Committee, and as a member and chairman of the Health Projects Committee. On the state level, Mrs. Hanson has been president; chairman of the Emergency Benevolent Fund, Long-Range Planning and Health Projects Committees; co-chairman of the AMA-ERF Committee; and a member and chairman of the Nominating Committee. In addition, she has served on the Governor's Committee on Immunization and on the Colorado Medical Society's Physician Health and Rehabilitation Committee.

WVSMA Auxiliary Annual Meeting Highlights

Wednesday, August 18

3:30 p.m. - 5 p.m.	Pre-Convention Board Meeting
6:30 p.m. - 7:30 p.m.	WVSMA Presidential Reception

Thursday, August 19

9 a.m. - noon	WVSMAA House of Delegates Southern Medical Auxiliary Address *(Ebba Dunn, SMAA president)*
11 a.m.	Active Parenting Program *(Novella Woodrum, counselor, The Family Center, Inc., Beckley)*
1:30 p.m.	Tennis Tournament
2 p.m.	Putting Tournament
6:30 p.m. - 7:30 p.m.	Reception hosted by CNA/McDonough Caperton
9 p.m. - 11 p.m.	Dance Lessons *(featuring Jerry and Sherry Rose)*

Friday, August 20

8 a.m.	Past Presidents' Breakfast
9 a.m. - noon	WVSMAA House of Delegates Second Session AMAA Address *(Mary Hanson, AMAA president)* Installation of 1993-94 WVSMA Alliance Officers
12:30 p.m.	President's Luncheon
2 p.m.	Bridge Tournament
9 p.m. - 1 a.m.	Dance "Spectrum of Music" *(informal attire)*

Saturday, August 21

9 a.m. - noon	Post Convention Board Meeting
4 p.m. - 5 p.m.	Reception Honoring Newly Installed Officers of the WVSMA & WVSMA Alliance

A former president of her local auxiliary, the El Paso County Medical Society Auxiliary, Mrs. Hanson has also been president of this organization's Loan Foundation and has served on many of its committees. Involved in many community endeavors, she has served on the board of directors of the American Cancer Society for El Paso County, the High School Parent Advisory Committee, the Elementary School Enrichment Committee for the Arts and Music, and the board of directors of the Friends of the Pioneers' Museum.

Mrs. Hanson has a bachelor of science degree in medical technology. She and her husband, Jerome, a plastic and reconstructive surgeon, are the parents of two children.

Mrs. Dunn has held leadership roles with the AMA Alliance in addition to her positions with the Southern Medical Association Auxiliary and the Auxiliary to the Medical Association of the State of Alabama.

A member of the AMA Alliance's 1990 Nominating Committee, Mrs. Dunn has served as southern director; member and chairman of the Election Committee; and as a member of the Bylaws, Long-Range Planning, Health Projects and the Reference Committees.

In addition to serving as president of the Southern Medical Association Auxiliary, she has held the positions of president-elect, first vice president, Eastern Region vice-president, councilor, vice-councilor, and as a member of the Long-Range Planning Committee. On the state level, Mrs. Dunn has been president of the Auxiliary to the Medical Association of the State of Alabama, as well as vice president, district vice president, corresponding secretary, treasurer, historian, and has also served as a member of the Long-Range Planning Committee and the President's Advisory Board.

Mrs. Dunn holds a bachelor of science degree from the University of Alabama. Her husband, Julius, is in family practice medicine in Wetumpka, Ala., and the Dunns have four children and one grandchild. Mrs. Dunn is devoted to many community activities and has been the organist for her church for 22 years.

New president highlighted

Carole Scaring was born in St. Louis, Mo., where she graduated from Fontbonne College and began teaching high school physical education and biology.

Mrs. Scaring and her husband, William, an ob/gyn, spent the first 10 years of their marriage living in several different cities in the United States and the Philippines while he was on active duty with the Navy. Carole continued her teaching career during this time and was busy raising their four children.

Following Dr. Scaring's years with the Navy, the Scarings moved to Chicago and Mrs. Scaring began teaching classes in adaptive aquatics for handicapped children. After living in Chicago for 15 years, the Scarings relocated to their present home in Beckley in 1987.

Soon after moving to Beckley, Carole joined the Raleigh County Medical Society Auxiliary and became especially active on the Health Committee. She established the Smoking Cessation Program at Raleigh General Hospital and she conducts clinics every spring and fall.

Mrs. Scaring served as president of the Raleigh County Medical Society Auxiliary for two years and was chairman of its Legislative Committee for two years. She has also been in charge of several fundraisers for the charitable organizations in Beckley. In addition, Carole has served the WVSMA Auxiliary as a regional director and as secretary and president-elect.

WVU professor to speak at Surgery Section breakfast

Herbert E. Warden, a professor of cardiovascular and thoracic surgery at West Virginia University, is the featured lecturer for this year's WVSMA Surgery Section breakfast meeting on Friday, August 20 at 7:30 a.m. during the WVSMA's Annual Meeting at The Greenbrier.

The topic for Dr. Warden's presentation is "Current Management of Thoracic Outlet Syndrome: Indications and Contraindications." Dr. Thomas Chang, chairman of the WVSMA Surgery Section, is encouraging all interested physicians and other health care professionals to attend this meeting, as well as this year's Thomas L. Harris Address, which will feature another renowned surgeon, John G. Hunter, M.D. Dr. Hunter is an associate professor in the department of surgery at Emory University and he will deliver his presentation, "The Current Status and the Future of Laparoscopic Surgery," during the Second Session of the WVSMA House of Delegates. This session will begin at 8:30 a.m. following the Surgery Section breakfast meeting.

Warden

Dr. Warden is a native of Cleveland who received his medical degree from the University of Chicago School of Medicine in 1946. He interned at the University of Chicago Clinics and completed his residency at the University of Minnesota Hospital, where he also did postgraduate study in surgery and physiology.

A fellow and a governor of the American College of Surgeons, Dr. Warden is also a fellow and former governor of the American College of Cardiology. The recipient of numerous honors during his career, Dr. Warden has been awarded the Albert Lasker Award for Medical Research by the American Public Health Association, the Hektoen Gold Medal of the AMA, and the J. Maxwell Chamberlin Award by the Society of Thoracic Surgeons.

To make reservations to attend the WVSMA Surgery Section breakfast meeting, please contact Nancie Divvens at 925-0342.

Press Conference

Reporters listen as WVSMA President Dr. Robert Pulliam expresses his concerns about the negative impact the new Medicaid Providers Tax will have on health care in West Virginia. Dr Pulliam addressed members of the media at a press conference which was held at the WVSMA office on Friday, July 2.

First Annual NIPP Invitational Golf Tournament set for Lakeview Resort

Don Knotts

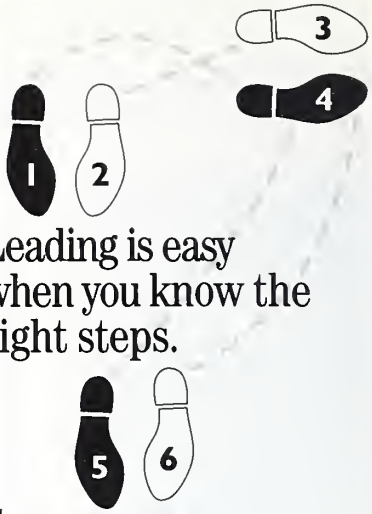
The Neurological Injury Prevention Program (NIPP), a collaborative effort of the West Virginia State Neurological Society and MountainView Regional Rehabilitation Hospital in Morgantown, is sponsoring the first Annual NIPP Invitational Golf Tournament on August 15 at Lakeview Resort and Conference Center. Actor Don Knotts, a native of Morgantown who is a strong supporter of the NIPP program, will be a special guest at the tournament.

Dr. T. Glenn Pait, a neurosurgeon at West Virginia University who directs NIPP, initiated this non-profit program in an effort to educate the state's youth about the importance of preventing brain and spinal cord injuries.

"Head injury is a silent epidemic in our nation," Dr. Pait said. "It afflicts more than 700,000 Americans each year. Three fourths of all teenage deaths between the ages of 15 and 24 are caused by accidents, and more than 400,000 brain and spinal cord injuries occur each year.

"Injury to the brain and spinal cord is devastating. Life for the individual and family is never the same again. The brain and spinal cord are most unforgiving. When they are injured, recovery, in most cases, is not complete. What is sad about all of this is that, in most cases, the injury was preventable. What we must do is educate people about how vulnerable their brains and spinal cords are."

For details about the golf tournament, phone Tammy Wilt at 1-800-388-2451.



Leading is easy when you know the right steps.

Interactions
Medical Staff Leadership Conference on Managing Change
October 1-3, 1993 Naples, Florida

We can't dance around the issue any longer. Health system reform is occurring at a fast pace. And it's going to take some fancy footwork for physicians to maintain autonomy and control within their practices.

Master the moves that will help you excel in this environment by attending the fourth annual Interactions Medical Staff Leadership Conference: Managing Change. Sponsored by the American Medical Association (AMA), in cooperation with the Medical Association of Georgia and the Florida Medical Association, this comprehensive three-day conference is designed specifically for new and experienced medical staff leaders.

Physician leaders will benefit by:
- Learning how to hone their leadership skills
- Gaining a greater understanding of health policy and medical practice issues
- Acquiring the knowledge and tools to deal with the changes surrounding health system reform

So lead, don't follow. It's easy, when you know the right steps. For more information or to register, call **800 621-8335** now!

American Medical Association
Physicians dedicated to the health of America

The WVSMA & Conomikes Associates, Inc.

Present

MANAGED CARE

How to deal with it properly

- How to avoid HMO/PPO contracting traps
- Capitation vs. Fee-for-Service
- How to get paid what you deserve

Charleston - September 28 Charleston Area Medical Center
3110 MacCorkle Avenue
9 a.m. to 4 p.m. (Lunch provided)

Registration Form

MANAGED CARE: How to deal with it Profitably

Enrollee Name _____

Physician's Name _____

Address _____

City _____

State _____ Zip _____ Phone _____

WVSMA member ($195) _____ Non-member ($225) ____
2 or more ($175) _____ 2 or more ($200) _____

Payment by: Check ___ Visa ___ Mastercard ___

Card Number _____

Expiration Date _____

Signature _____

Registration Fees:

$195 per person (Members/Member's Office staff)
Two or more persons from the same practice $195 for the first enrollee and $175 for each additional enrollee

$225 per person (Nonmembers/Office Staff)
Two or more persons from the same practice $225 for the first enrollee and $200 for each additional enrollee

NOTE: To register more than one person, copy and complete information on a separate sheet.

If paying by check, please send registration form and check to:

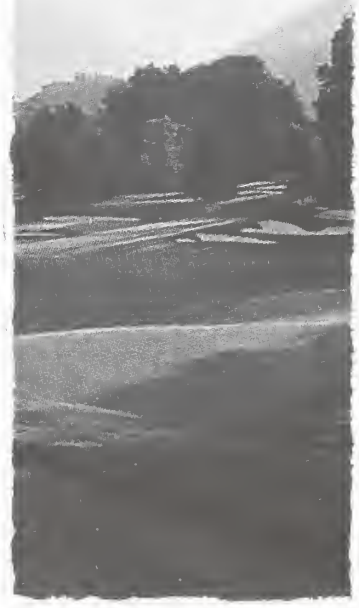
West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

In 1778, healing sulphur springs were discovered in the scenic Allegheny Mountains. Within a few years, a college community was formed nearby, eventually evolving into a small resort. Today The Greenbrier is designated a National Historic Landmark, and its guests have included 22 U.S.

Presidents as well as other world leaders and prominent personalities. This historic background, plus unlimited activities, superb amenities

and its mountain location have earned The Greenbrier its reputation

West Virginia's Resort. Where heritage and beauty are one.



as America's Resort. And especially, West Virginia's Resort. Whether it's

a romantic weekend, a relaxing golf getaway or a rejuvenating spa vacation, you'll always find the perfect combination of relaxation

and recreation, beauty and heritage at The Greenbrier. Call (800) 624-6070 or (304) 536-1110 or see your travel agent. Easy access by auto, over Interstate highways. The Greenbrier, White Sulphur Springs, West Virginia 24986. A CSX Resort.

The Greenbrier®
America's Resort
A member of The Leading Hotels of the World®

The West Virginia State Medical Association's

1993 Annual Meeting

August 18-21, 1993

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up Now!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

For more details about other area hotels/motels, contact the WVSMA at 304-925-0342. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1993 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code _____

Specialty _____

Payment by: Check Visa MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	____
	non-member	$175	____
Additional:			
Thursday, Aug. 19 Lunch and Learn (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
Friday, Aug. 20 WESPAC Luncheon (CME Credit)	member/non-member	$25	____
	spouse/student	$15	____
		TOTAL:	____

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Lunch & Learn

"*Family Violence* - Exploring the Caregivers' Legal and Ethical Responsibilities"

Cleveland attorney Ronald E. Alexander will headline a panel discussion on the physician's role in assisting the victims of domestic violence. Other panelists include William H. Beeson, M.D., president of the Indiana State Medical Association; Joseph Snyder, M.D., president of the Medical & Chirurgical Faculty of the State of Maryland; Stanley J. Lucas, M.D., president of the Ohio State Medical Association; George Broman Jr., M.D., president of the Medical Society of Virginia; William B. Monnig, M.D., president of the Kentucky Medical Association; and Pacita Salon, president of the WVSMA Auxiliary.

August 19, 1993 at Noon
in the McKinley Room at The Greenbrier

This CME luncheon will provide a valuable opportunity for participants to learn about the legal perspectives of family violence situations, as well as share their own personal experiences.

The cost for the luncheon is $25 for physicians and $15 for all other interested guests. Seating is limited. Tickets will be available at the Registration Desk in the Exhibit Hall or send a check payable to the WVSMA with the form below to: WVSMA, P.O. Box 4106, Charleston, WV 25364. For more information, call the WVSMA office at 304/925-0342.

Lunch & Learn - "Family Violence"

Name _____

Address _____

_____

Phone _____

_____ Physician _____ Auxilian _____ No. Attending

Lunch & Learn

"Politics, Your Practice & Your Patients"

Visiting state presidents from Pennsylvania, Maryland, Ohio, Indiana and Virginia, as well as Dr. Joseph Painter, president of the AMA, will be participating in a question and answer session on how POLITICAL ACTION COMMITTEES affect the legislative process.

What is a PAC's role in the legislative process?
How do other state PACs select their candidates to endorse?
What is the PAC's role within the medical society?
What is the future of PACs on a national and state level?

August 20, 1993 at Noon
During the WVSMA Annual Meeting
in the Taft Room at The Greenbrier

This CME luncheon will be moderated by James L. Comerci, M.D., president-elect of the WVSMA. The cost for the luncheon is $25 for physicians and $15 for all other interested guests. Seating is limited. Tickets will be available at the Registration Desk in the Exhibit Hall or mail in the form below with a check made payable to the WVSMA to: WVSMA, P.O. Box 4106, Charleston, WV 25364.

IF YOU'RE INTERESTED IN POLITICS AND ARE CONCERNED
WITH THE FUTURE OF HEALTH CARE - -
DON'T MISS THIS MEETING!

Lunch & Learn - "Politics, Your Practice & Your Patients"

Name _____

Address _____

Phone _____

_____ Physician _____ Auxilian _____ No. Attending

1993-94 WVSMA Delegates/Alternates

BOONE (2) Names not submitted

BROOK (2)
Delegates: W. T. Booher, P. P. Cipoletti Jr.
Alternates: L. P. Velarde, R. L. Velarde

CABELL (16)
Delegates: Daniel F. Carr, G. William Lavery, Joseph Locascio, Carl F. McComas, Jose I. Ricard, Thomas F. Scott, Jack R. Steel, Philip R. Stevens, Elaine M. Young
Alternates: Nazem Abraham, Jack Baur, Paul Blair, Colin M. Craythorne, Estelito B. Santos, Gary G. Gilbert, Adel A. Ibrahim, Robert Lowe, Joseph B. Touma

CENTRAL WV (3)
Delegates: Steven Cirreli, Clemente Diaz, Rigoberto Ramirez
Alternates: Arnold Gruspe, Joe Reed

EASTERN PANHANDLE (4)
Delegates: Edward F. Arnett, Joseph McCabe, Edward L. Pinney Jr., Harvey D. Reisenweber
Alternates: Names not submitted

FAYETTE (2)
Delegates: Sam Davis, Miraflora Khorshad
Alternates: Names not submitted

GREENBRIER VALLEY (3)
Delegates: Allen Lee, Stephan Thilen
Alternates: Names not submitted

HANCOCK (3)
Delegates: Charles Capito, Brijinder Kochhar, Sarjit Singh
Alternates: Young Lee, Gurdev Purewal

HARRISON (5)
Delegates: Thomas H. Chang, Erlinda De La Pena, Robert Hess, Saad Mossallati, David Waxman
Alternates: Cordell De La Pena, Charles LeFebure

KANAWHA (19)
Delegates: Nicholas Cassis Jr., Ronald E. Cordell, W. Alva Deardorff, Donald Farmer, Michael Fidler, John Hartman, Sherman E. Hatfield, Fred F. Holt, Lester Labus, John B. Markey, John Merrifield, Lee L. Neilan, Jim Mangus, Stephen Perkins, William Sale, Ralph Smith, Elizabeth Spangler, James Spencer, F. Thomas Sporck
Alternates: L. S. Agrawal, Albert Capinpin, Shawn Chillag, Ted Jackson, R. T. Linger Jr, Daniel MacCallum, Lewis McConnell, Lawrence Minardi, Ross S. Oliver Jr., Thompson E. Pearcy, Richard Rashid, David Ritchie, Ujjal Sandhu, Jose Serrato, Joseph T. Skaggs, Samuel Strickland, Muhib Tarakji, J. D. Teodoro, Caroline Williams

LOGAN (3)
Delegates: Raymond Rushden, Rajendra Valiveti
Alternates: Rajendra Bellam, Judith Bredemuehl, Narcisco Tuanquin

MARION (4)
Delegates: Joedy Daristotle, John A. Leon, Mike Schroering, Stan Swihart
Alternates: Prasad Devachaktuni, Dave McLellan, Jack Porvaznik, Li-Hsia Wang

MARSHALL (2)
Delegates: Kenneth Allen, Jesus T. Ho
Alternates: Names not submitted

MASON (2) Names not submitted

MCDOWELL (2)
Delegates: Alexander Herland, C. Anderson
Alternates: Charito Flores, Charles Michaelis

MERCER (4)
Delegates: Generoso Duremdes, T. Keith Edwards, John J. Mahood, Gopal Pardasani
Alternates: Michael Alexander, William Prudich

MONONGALIA (27)
Delegates: Russell Biundo, Robert D'Alessandri, Anthony Di Bartolomeo, Douglas Glover, James Helsley, Ronald Hill, Richard Kerr, Roger King, Paul Malone, David Z. Morgan, John Pearson, V. K. Raju, Ralph Ryan, Steven Sebert, Jeff Stead, James Stevenson
Alternates: Names not submitted

OHIO (9)
Delegates: Terry Elliott, Michael Fortunato, Bart Herschfield, John Holloway, Steven Miller, Dennis Niess, M. D. Reiter, William D. Strauch, Daniel Wilson
Alternates: Names not submitted

PARKERSBURG ACADEMY (7)
Delegates: John E. Beane, Samuel Guy, Dennis Mlot, Michael Morehead, Harry Shannon, Rutherford Sims
Alternates: Paul Burke

POTOMAC VALLEY (2) Names not submitted

PRESTON (2)
Delegates: Darryl L. Landis
Alternates: Names not submitted

PUTNAM (2) Names not submitted

RALEIGH (7)
Delegates: Wallace Johnson Jr., Lamberto Maramba, Husam Nazer, Iligino Salon, William Scaring, Rajnikant Shah, Norman Taylor
Alternates: Sung Chang, Ahmed Faheem, Lewis Fox, Cecil Graham, Ramon Jereza, Teofilio Rojan Jr, Nancy Webb

SOUTH BRANCH VALLEY (2) Names not submitted

SUMMERS (2) Names not submitted

TUG VALLEY (2) Names not submitted

TYGARTS VALLEY (3)
Delegates: Mary E. Myers, Joseph Tavolacci, Christopher Villaraza II
Alternates: Sam Krinsky, Karl J. Myers Jr.

WESTERN (2)
Delegates: Pedro Ambrosio, James Hughes
Alternates: Erlinda Ambrosio, Ali Morad

WETZEL (2) Names not submitted

WYOMING (2) Names not submitted

WVSMA Tournaments

Join in the Annual Meeting fun!

...Volleyball

Derrick L. Latos, MD, Chairman

T-shirts courtesy Sandoz
Prizes by WVSMA

...Tennis

ElyJean C. Salon, MD and Prospero B. Gogo, MD
Co-Chairmen

Trophies courtesy A.H. Robbins

And Golf....

Estelito Santos, MD, Chairman
Trophies courtesy Roche Laboratories

Registration

Golf - Golf Pro Shop
Tennis - Tennis Pro Shop
Volleyball - WVSMA Registration Desk

All tournaments begin Thursday, Aug. 19 at 2 p.m.

Be a part of the ACTION!

1993 WVSMA Annual Meeting Exhibitors

ADVA CARE, INC.
Vicky S. Cawley

ADVANCED BENEFIT DESIGN SERVICE
George D. Brown, Mark L. Matson,
William W. Mucklow

ADVANCED ORTHOPEDIC TECHNOLOGIES, INC.
Terri L. Bailey, Gerald K. Lett, Bill Lovegreen

ALLAN & HANSBURY
Tom Kenney

APPALACHIAN REGIONAL HEALTHCARE, INC.
Greg Davis, Scott Franklin, Gary Smock

BRISTOL LABORATORIES
Jose Testa, James Winslow

BRISTOL - MYERS - SQUIBB
E.R. SQUIBB - PPP
Joseph A. Oliverio Jr. - ERS, Jane Richards, PPP

CHARLESTON AREA MEDICAL CENTER
Raymond Cunningham, Bruce Cartwright

CNA INSURANCE COMPANY/
MCDONOUGH CAPERTON INSURANCE GROUP
Steve Brown, Elaine Grimm, Bob Jones, Tamara Lively,
Gary Shields, Michele Marie Sull

CENTER FOR ORGAN RECOVERY & EDUCATION
Jan Aston, RN, Alana Powers, RN

EASTMAN KODAK COMPANY
Bruce M. Kaufer

FAMILY MEDICINE FOUNDATION OF WV
Chris Ferrell, Alice Jo Hess

HEALTHCARE FINANCIAL SERVICES
J. Bruce Dunlap, Thomas M. Harris

IMAGE TECHNOLOGY, INC.
Tony Bonner

JOHN HANCOCK FINANCIAL SERVICES OF WV
Scott D. Adams, Maria Jenkins, Gayle McCormick,
Gene Riggs, Debi Rhoades, Roger Taylor, Larry Woods

KEY PHARMACEUTICAL
Tom Christy, Jon Lipps, Mike McCann

LANHAM O'DELL AND COMPANY
Names not submitted

MARION MERRELL DOW, INC.
Names not submitted

MARSHALL UNIVERSITY SCHOOL OF MEDICINE
Gay Jackson

MCLAIN SURGICAL SUPPLY, INC.
Tim Fleming, Erick D. Schwarz, Gary A. Schwarz

MEAD JOHNSON LABORATORIES
Melanie Barr, Lydia Sanders

MEDICAL OFFICE MANAGER
Jim Isabella, Jerry Steele

MED-X
Fred Bonham, Rick Crigger, Bonnie Young

MERCK & COMPANY, INC.
Harold Ashworth

MERRILL LYNCH
Hal L. Darnold, Larry Richards, Richard Wilson

MICROSYS COMPUTING, INC.
William C. Davidson

MILES INC., DIAGNOSTICS DIVISION
Alvin G. Chesson, Robert E. Kidd

MONY - MUTUAL OF NEW YORK
Jim Hall, Mart Karner, Eddie Queen, Mike Zuverink

MOUNTAINVIEW REGIONAL REHABILITATION HOSPITAL
Jan Everly, RN, Patty Pearson

NEW CENTURY IMAGING INC.\DATA STORAGE INC.
Dee Mullooly

THE P.I.E. MUTUAL INSURANCE COMPANY
Julie Ayers, Phyllis Myers, Jim Winterich

PRATT PHARMACEUTICALS/PFIZER, INC.
John Brunetti, Jeanne MidKiff, Jim Stumpff

RHONE-POULENC RORER PHARMACEUTICAL
Earl Lawson, Cleatus Price, Kathryn Thalman

ROBERT C. BYRD HEALTH SCIENCES CENTER OF WVU
Kari L. Long, Julie Moore, Tammy Mozuke

ROERIG DIVISION OF PFIZER
Vanessa Harris

ROSS LABORATORIES
Norman A. Craig, Dean Fliotsos, Philip E. Pini

SCHERING CORPORATION
Kimberly Combs, Robert Preece

SEARLE
Susan Callison, Robert Hogan, Cecilia Lynch, Eric Petry, John Scherer, Natalie Egnor-Walker

SMITHKLINE BEECHAM PHARMACEUTICAL
Bob Bucina, Jon Lipps, Tom McGinley, Doug Wallace, Stephen Ward

SOUTHERN MEDICAL ASSOCIATION
Chip Dawson

UMWA HEALTH & RETIREMENT FUNDS/ FIRST HEALTH
Lorilei Friday, Connie Lipcsak, George Olson

VISIONS, A SHAWNEE HILLS SUBSIDIARY
Donna Hastings, Paulette Justice, Bev Wheatcraft

WALLACE LABORATORIES
Karen Orsetti

WV BUREAU OF PUBLIC HEALTH
Cathy Lee

WYETH-AYERST LABORATORIES
Theodore Marchal, Belinda Smiley

THANKS!!

A special word of appreciation goes to the following firms who have contributed educational grants or other support for this year's WVSMA Annual Meeting. The support given by these organizations makes possible the educational emphasis of the meeting:

The Chapman Printing Company
CNA Insurance Companies
Glaxo Pharmaceuticals
The Greenbrier Hotel
Marshall University School of Medicine
McDonough Caperton Insurance Group
MCV Alumni Association
P.I.E. Mutual Insurance Company
Roche Laboratories
Sandoz Pharmaceuticals
West Virginia University Alumni Association
West Virginia University School of Medicine
Wyeth Ayerst/A.H. Robins Company

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

CAMC/WVU Health Sciences Center - Charleston

Aug. 19 - "Catastrophic Sports Injuries" (teleconference), noon - 1 p.m., WVU Health Sciences Center and satellite locations

Marshall University - Huntington

Sept. 10 - "Third Annual Cancer Conference," St. Mary's Hospital

Sept. 10-11 - "MU School of Medicine Alumni Weekend," Radisson Hotel

Robert C. Byrd Health Sciences Center of WVU - Morgantown

Aug. 29-Sept. 2 - "Oxygen Radicals and Lung Injury" (sponsored by the WVU Dept. of Pathology and NIOSH), Lakeview Resort and Conference Center, Morgantown

Sept. 24-25 - "Surgery Update 1993*" (sponsored by the WVU Dept. of Surgery and the West Virginia Chapter of the American College of Surgeons), Robert C. Byrd Health Sciences Center, Morgantown

**Held in conjunction with a home football game*

West Virginia State Medical Association - Charleston

Aug. 18-21 - "WVSMA's 126th Annual Meeting," White Sulphur Springs

Sept. 9 - "Office Personnel Loss Control Program," Morgantown

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/WVU Health Sciences Center, Charleston*

Fairmont ★ Fairmont Clinic, Aug. 18, 1 p.m., "End Stage Renal Disease and Pathophysiology and RX of CRF," Michael Sorkin, M.D.

★ Fairmont Clinic, Sept. 15, 1 p.m., "Office Dermatology," William Welton, M.D.

Man ☐ Man Appalachian Regional Hospital, Aug. 17, 7 p.m., "Domestic Violence," Ralph Smith, M.D.

New Martinsville ★ Wetzel County Hospital, Aug. 12, 11:30 a.m., "Occupational Lung Diseases," Daniel Banks, M.D.

★ Wetzel County Hospital, Sept. 9, 11:30 a.m., "Double Vision," Lenore Breen, M.D.

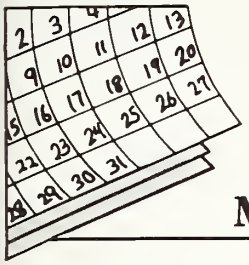
Point Pleasant ☐ Pleasant Valley Hospital, Aug. 26, noon, "New Skin Conditioning Programs in Peels," Alfonso Amores, M.D.

Ripley ☐ Jackson General Hospital, Aug. 13, 12:15 p.m., "Echocardiography for Primary Care Physicians," Ganpat Thakker, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Aug. 23, 4 p.m., "Bites and Stings," William Ramsey, M.D.

**To be announced*

"I THINK I UNDERSTAND EVERYTHING, DAD... BUT HOW DOES THE BEE PUT ON A CONDOM?"



Medical Meetings

August

18-21–WVSMA's 126th Annual Meeting, White Sulphur Springs
21-25–American Association of Tissue Banks, Boston
25-27–Advanced Cardiac Stimulation Seminar (sponsored by Ohio State University), Chicago

September

5-9–62nd European Atherosclerosis Society Congress, Jerusalem, Israel
7-12–American Academy of Neurological and Orthopaedic Surgeons, Las Vegas, Nev.
9-11–American Gynecological and Obstetrical Society, LaCosta and Carlsbad, Calif.
9-12–Colorado Medical Society's 1993 Annual Meeting, Snowmass, Colo.
10-11–Where are the Donors? Strategies for Expansion of the American Donor Pool (sponsored by the American Association of Blood Banks), Arlington, Va.
10-12–Primary Care Update and Board Review, The George Washington University Medical Center, Washington, D.C.
11-14–The Decade of the Brain: An International Conference (sponsored by The George Washington University Medical Center), Washington, D.C.
18-20–7th Annual Brachytherapy Symposium: Focus on High Dose Rate Brachytherapy and Intraoperative Radiation Therapy (sponsored by Ohio State University), Columbus
19-24–Intense Total Body, Ortho, Neuro MRI Review (sponsored by the MRI Education Foundation), Cincinnati
20–National Eye Care Forum (sponsored by the American Academy of Ophthalmology), Washington, D.C.
20-22–17th National Conference on Correctional Health Care (sponsored by the National Commission on Correctional Health Care), Orlando
22-26–Management Imperatives (sponsored by the Practice Management Institute), Lake Tahoe, Calif.
26-27–Introductory Perimetry (sponsored by Ohio State University), Columbus

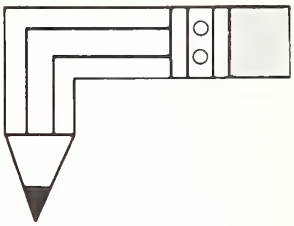
October

1–Recertification: New Evaluation Methods and Implementation Strategies (sponsored by the American Board of Medical Specialties Research and Education Foundation), Chicago

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Listening

For those who have ears,
Let them hear,
For those whose ears
No longer hear,
They may listen yet
With their mind and heart.
For this listening,
Lets them hear
The soundless voice
Of the Universe,
That speaks to us
unendlingly,
As that is THE VOICE
OF GOD,
That is forever audible,
To us all,
If we would only listen.

James T. Spencer Jr., M.D.

Belief

Belief in something or someone
More powerful than we
Who created and controls
This vast universe we see
Is something innate to each of us.

But there are those who say it nay;
Who say they don't believe.
What purpose do they see in life;
To what hope can they cleave?
To them life is unjust.

Yet this belief is a common thread
Running through humanity;
It's something we depend upon
To liberate and set us free;
A higher power we can trust.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Provisional Vital Statistics Report released for 1992

The 1992 West Virginia Provisional Vital Statistics Report, which contains preliminary information on such subjects as the total number of births, deaths and marriages, was recently released by the Bureau of Public Health's Office of Epidemiology and Health Promotion.

The report shows that in 1992 the number of births in the state decreased from 22,509 in 1991 to 21,261. The number of births to teenage mothers also decreased, going from 3,952 in 1991 to 3,712, with births to teens comprising 17.5% of all state births.

There were 19,054 deaths in West Virginia in 1992, down from 19,951 in 1991. The death rate fell slightly to 10.6 deaths per 1,000 population in 1992, from 11.1 in 1991. Heart disease and cancer remained the leading causes of death, accounting for 35.3% and 23.5% of all state deaths, respectively.

In other statistics, the number of deaths to infants under one year of age rose to 194 deaths in 1992, up from 183 in 1991. The state's provisional infant mortality rate of 9.1 deaths per 1,000 live births exceeded the national provisional rate of 8.6, and was up from the state rate of 8.1 in 1991, which had been the lowest infant mortality rate ever recorded in West Virginia.

Final 1992 vital statistics will be released later this year and a copy of the current report is available from Genie Thoenen at (304) 558-9100.

Canaan Valley site for EMS conference

This year's 17th Annual Emergency Medical Services Conference, "The World of EMS," will take place at the Canaan Valley Resort and Conference Center from September 16-17.

Workshops include "Mass Casualty Planning and Response," "Basic Burn Management," "Geriatric Patient Assessment," "A Systems Approach to EMS for Children," "Hand and Spinal Injuries," "Integrating Paid and Volunteer Personnel," "Discrimination and Sexual Harassment in EMS," "Creative Teaching Techniques," "Moulage Techniques," "Penetrating Trauma," "Setting Standards for EMS," "Triage," "Communicating with the Disabled," "Cold-Related Emergencies," "National Organizations and EMS" As a Profession," "Review of Medical Examiner Cases," "Careers in EMS" and Quality Improvement for EMS."

Participants will include public officials, EMS program directors, medical advisors, administrators, EMS instructors and emergency medical technicians and paramedics.

For more information, phone Carla Zando at (304) 558-3956.

WVPHA plans annual meeting in September

The 69th Annual Meeting of the West Virginia Public Health Association is scheduled for September 21-24 at the Canaan Valley Resort and Conference Center and is entitled "Public Health – Responding to Change."

Keynote speakers include Eugene Feingold, Ph.D., president-elect of the American Public Health Association, who will discuss national health care reform; and Bob Cheyne, director of marketing for the Sam's Wholesale Clubs chain, who is scheduled to provide a motivational outlook on dealing with change. In addition, Bureau of Public Health Commissioner William T. Wallace Jr., M.D., M.P.H., will discuss health care reform and its impact on local health at a luncheon for area health officers on September 23.

Other topics include updates on new CLIA and OSHA requirements for laboratories, indoor air problems, new nutritional labeling laws, social marketing in public health, and hands-on training for dealing with the media on health issues.

For more meeting details, contact WVPHA President-Elect Chris Gordon at (304) 558-3210.

First statewide rural health conference planned for October

"Linking Community Development and Rural Health" is the theme for the first-ever statewide conference on rural health care issues, which will be held at the Beckley Hotel in Beckley from October 16-18.

This event is a joint effort between the Bureau of Public Health, the state's three medical schools, health care provider associations and a number of individual health care institutions. It will be funded in part with a $15,000 grant from the Claude Worthington Benedum Foundation.

Denise Denton, president of the National Rural Health Association, and Sally Richardson, director of the West Virginia Public Employees Insurance Agency, are scheduled to address participants about national health care reform and how it may impact rural health care. In addition, John Malden, M.D., of Marshall University, will discuss primary care practice in low-resource environments; and Mary Huntley, director of the Bureau of Public Health's Office of Community and Rural Health, will make a presentation on community care networks and their implications for public health departments, primary care centers and private practice health care providers.

Other focus areas of the conference include health professions' education, community organization, and the relationship of health care systems to the overall structure of communities.

The conference is designed for health care providers and administrators, business and community leaders, extension agents and all other individuals interested in community development and improving the health of local communities.

For registration materials or more information on the conference, contact Elise Jensen of the Bureau's Office of Rural Health Policy at (304) 558-1327.

Ed's MED
Medical Waste Systems

We specialize in the legal transportation and disposal of infectious waste.

With our medical disposal service, you can expect:

- on site consulting
- a complete line of packing supplies
- outside storage containers
- trained, courteous employees
- disposal by incineration

Service is our priority.

Ed's MED - A Division of Ed's All Clean Disp., Inc. - P.O.Box 6324 Charleston, WV 25362 - (304) 342-4867 - (800) 345-4660

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Turnkey
Business Systems, Inc.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown.

Heart surgeons perform state's first autograft operation

WVU surgeons recently performed the state's first autograft heart valve replacement operation. The surgery is significant because it is the first time doctors have used one of the patient's own valves instead of implanting an artificial one.

"This is a milestone in the surgical treatment of valvular disease in West Virginia," says Dr. Jose Cruzzavala, assistant professor of surgery. "Although it has been tested for more than two decades, few medical centers in the country use this very complex surgical technique."

Dr. Cruzzavala calls it a "switch operation" because it involves replacing the defective aortic valve with a pulmonary valve. The pulmonary valve is replaced with a preserved human valve.

WVU recently established a tissue bank for preserving and storing donated human valves (called homografts). The bank shares human valves with other institutions that maintain banks.

NCI and WVU sign $3.5 million contract

The National Cancer Institute (NCI) has selected the Mary Babb Randolph Cancer Center to provide cancer information to residents of West Virginia, Ohio and most of Virginia.

The $3.5 million, four and a half year contract will require the Cancer Information Service at the Robert C. Byrd Health Sciences Center to answer more than 30,000 calls each year over the toll-free 1-800-4-CANCER service.

The Cancer Information Service has been handling calls for West Virginia and Virginia since 1989, but now the addition of Ohio to the regional contract will double the population served from Morgantown. In addition to the telephone information service, the Cancer Center will coordinate cancer prevention and education outreach efforts in the three states.

"We will work with other cancer centers, state and local health agencies, the American Cancer Society, and community programs throughout the three states," Pamela Brown, associate director for cancer information and education at the Cancer Center said. "Our role will be to link NCI programs with local efforts and provide educational materials for others to use."

Former engineer named new radiation oncology chief

Dr. Leroy Korb, a former chemical engineer with Union Carbide in Charleston, has been named the radiation oncology section chief for the Mary Babb Randolph Cancer Center.

A native of Warren, Pa., Dr. Korb graduated in 1986 from the WVU School of Medicine and received his specialty training at the University of Virginia at Charlottesville. Before accepting his new position, Dr. Korb was most recently affiliated with a radiation oncology group in Erie, Pa.

Certified by the American College of Radiology, Dr. Korb is married to Dr. Laurie Gutmann, a WVU neurologist.

Butcher promoted to senior associate vp

Fred R. Butcher, Ph.D., director of the Mary Babb Randolph Cancer Center, has been named senior associate vice president for health sciences by WVU, effective July 1. Dr. Butcher, who has led the Cancer Center since it opened in 1990, will continue as director until a successor is named.

As senior associate vice president, Dr. Butcher will be responsible for graduate education programs, development, and relations with WVU administrative and governing bodies. He will also have administrative responsibility for the University-owned facilities at the Robert C. Byrd Health Sciences Center and will oversee planning, renovation, and maintenance activities in the one million square foot Health Sciences Building.

Dr. Butcher is a research scientist who joined the WVU School of Medicine faculty as a professor of biochemistry in 1978.

UHS physicians participate in ACHA meeting in Baltimore

Three University Health Service (UHS) physicians participated in the annual meeting of the American College Health Association from May 28 to June 3 in Baltimore, Md.

Dr. Edwin J. Morgan, UHS director, attended the meeting as an institutional representative for the Director's Day Forum representing WVU. He conducted a symposium on the treatment of asthma in young adults.

Dr. John Vanin, director of UHS's Psychiatric and Health Education Programs, gave presentations on psychiatric medications and on school performance as the focus for innovative psychological interventions.

In addition, Dr. Christine Banvard, a UHS physician, participated in symposiums on HIV, alcohol and drug influences, and medicine for college athletes at the meeting.

Annual Hal Wanger conference scheduled

The School of Medicine's Office of CME will hold its 19th Annual Hal Wanger Family Medicine Conference from September 30 - October 2.

The two and a half day conference will focus on a broad spectrum of topics and is designed for family practitioners, osteopaths, nurse practitioners, physician assistants and nurses. Critical reviews and current approaches to issues in the health care of children and adults will be discussed.

Course credit will be offered and more details can be obtained by calling the Office of CME at 293-3937.

620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5

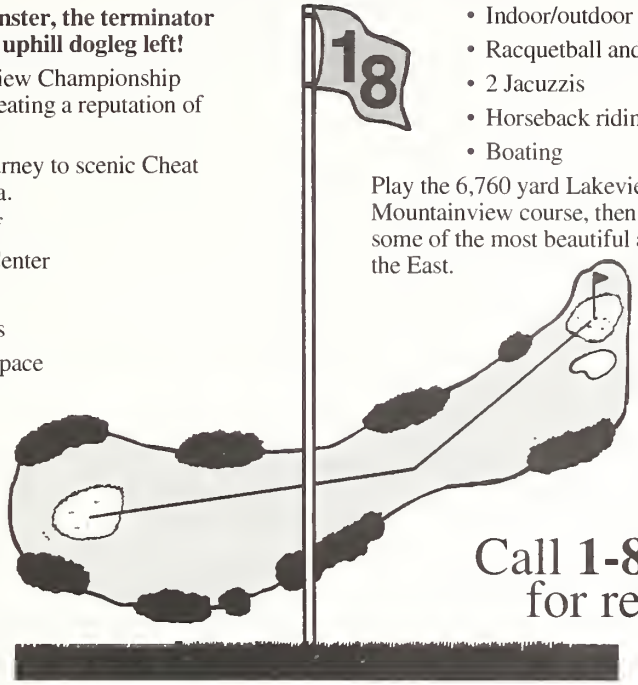
"Nobody Gets Home In Two"

And no wonder . . . this is the monster, the terminator of all holes, at 620 yards with an uphill dogleg left!

The famous hole #18 on the Lakeview Championship Golf Course is a legend in itself, creating a reputation of "Nobody gets home in two".

But that's not the only reason to journey to scenic Cheat Lake in Morgantown,West Virginia.

- 36 holes of Championship Golf
- $2 million Fitness and Sports Center
- 187 guest rooms and suites
- 75 two bedroom condominiums
- 24,000 square feet of meeting space
- 4 restaurants and lounges
- 3 swimming pools



- Indoor/outdoor tennis courts
- Racquetball and wallyball
- 2 Jacuzzis
- Horseback riding
- Boating

Play the 6,760 yard Lakeview course and the 6,447 yard Mountainview course, then you'll know you've played some of the most beautiful and challenging golf in the East.

LAKEVIEW RESORT & CONFERENCE CENTER

Call **1-800-624-8300** for reservations.

620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5

Your CPA: A Business Investment

Your company's not quite doing as well as you think it should, but you're not sure what to do about it. Certified Public Accountants have the education and experience to strengthen internal controls, provide management advice, understand business law, reduce your tax burden and help you with budgetary and financial planning.

Whether your CPA is a company employee or an outside consultant, this professional brings many unique qualifications to your business. Members of The WV Society of CPAs bring integrity, independence, ethical standards and continuing education to their work, backed by the resources of a 1,700-member professional association.

When you want to make a sound investment in your business, use a CPA.

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

MU, INCO Alloys create PPO partnership

As national policymakers struggle with the issue of health care reform, INCO Alloys International in Huntington has created its own solution to rising costs: an innovative PPO developed in partnership with the School of Medicine.

The modified PPO, named INCOnet Advantage, differs from "traditional" PPOs in several respects, according to Tim Crofton of Marshall.

"Unlike most PPOs, this one consists solely of primary care physicians who serve as employees' entry point into the health care delivery system," Crofton said. "Another distinction is that the program relies more on cooperation and education than on competition: currently the organization consists of 53 physicians, both from the Medical School and from the communities themselves, in the Huntington area and adjoining areas of Ohio and Kentucky," he added.

Inco realizes savings both through "extremely competitive" fees for managing the program and through avoiding inappropriate use of medical services by employee patients, Crofton said. In an enthusiastic letter to Marshall president J. Wade Gilley, INCO Director of Administration M. E. Cunningham called the program a model for other organizations.

"With Dr. Bob Walker and his staff, we have been able to roll up our sleeves and initially, with no more than a handshake, develop a managed care program in what has probably been record-setting time," Cunningham said. "Before INCOnet Advantage began in April, the company's medical costs had been growing at four times the rate of inflation. Medical costs had nearly doubled between 1985 and 1992, even though employment had dropped.

"The PPO has allowed us to maintain a high quality of medical care while establishing cost control measures that did not formerly exist. "Using the Department of Family and Community Health physicians and clinic sites as the backbone, Dr. Walker has put together a Preferred Provider Organization that has physicians located throughout our tri-state employment area. "To our knowledge, this is the only PPO in the country to be developed and associated with a medical school," he added.

Cunningham said Dr. Walker's efforts resulted in a better dialogue with the local medical community, not just with the primary care providers, but also with the subspecialists to whom they refer.

"This initiative represents partnerships in every facet of the system," Cunningham explained. "The cooperative effort between Marshall University and INCO Alloys has resulted in a managed care package that can be a model for other organizations. As the state authorities deal with health care reform, they would do well to follow the model our mutual efforts have produced."

NSF grant to boost cell molecular research

School of Medicine scientists will receive $3 million to advance cell molecular research, thanks to the National Science Foundation's renewal of a multi-project grant through its Experimental Program to Stimulate Competitive Research (EPSCoR).

According to L. Howard Aulick, Ph.D., assistant dean for research development, eleven faculty members drawn from every basic science department serve as investigators for the grant, which was first received two years ago.

"This renewal will allow expansion of all cell molecular projects covered under the initial grant, and will enhance the development of both research and graduate education in molecular biology," Dr. Aulick said. "Much of the early work under the EPSCoR grant has focused on defining and characterizing a hypertensive factor first identified by Gary L. Wright, Ph.D., chairman of Marshall's Department of Physiology. The renewal will support continuation of that work as well as allow diversification."

In its first two years, the program has established and fully equipped three core labs that provide research resources for Marshall faculty and the region: a calcium imaging facility for determining intracellular calcium levels, a tissue culture facility and a recombinant DNA facility.

The program also has resulted in the hiring of three faculty members, a 40 percent increase in the biomedical sciences graduate program enrollment and provided 15 competitive graduate student stipends. Besides Wright, other principal investigators will include Drs. Mitchell Berk, Carl Gruetter, Elsa Mangiarua, William McCumbee, Donald Primerano, Vernon Reichenbecher, William Rhoten and John Szarek.

In addition to the Marshall research, the West Virginia Science and Engineering Infrastructure Plan supported by EPSCoR includes non-medical projects at West Virginia University and state colleges. The National Science Foundation grant totals $3.6 million over the next three years, with matching funds provided by the state of West Virginia.

Alumni Weekend set for September 10-11

Alumni and friends of the Marshall University School of Medicine will meet September 10 and 11 for the annual alumni weekend.

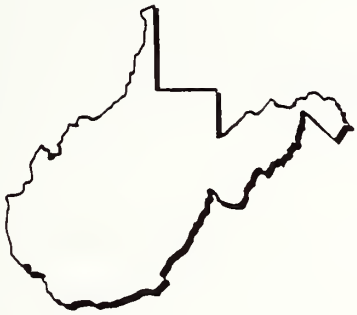
Events begin with Dr. Pat Brown's faculty/alumni mixer on Friday evening at the Radisson Hotel in Huntington. Saturday's activities will start with concurrent grand rounds in surgery, internal medicine, family practice, combined pediatrics and basic sciences. The keynote luncheon speaker will be cardiologist Dr. Gerry Blackwell of Marshall's class of 1983. Other events will include a tailgate party, the Marshall University/Murray State football game, and a postgame reception.

For information and registration, call 696-7019.

HealthCare Financial Services

"Your Medical Collection Specialists"

Looking for an edge in healthcare collections?



HFS provides **statewide** service, complete with:

* Automated dialer
* Statewide wats service
* Effective collections on medical accounts
* Trained, experienced staff
* Prompt account acknowledgement

A division of Strategic Health Services, Inc. • Affiliated with Charleston Area Medical Center

1204 Kanawha Boulevard, East • P.O. Box 3882 • Charleston, WV 25338
Phone: (304) 345-4371 • (800) 369-4371 • Fax: (304) 345-4323

RUN A SPECIAL PRACTICE.

Today's Air Force has special opportunities for qualified physicians and physician specialists. To pursue medical excellence without the overhead of a private practice, talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay each year that are part of a medical career with the Air Force. Discover how special an Air Force practice can be. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

Auxiliary News

Farewell Message

As I conclude my presidency, I would like to express my thoughts and experiences about the WVSMA Auxiliary (soon to be renamed Alliance) and the successes we proudly achieved this year.

First, I must begin with the American Medical Association Alliance. Through this organization, I was trained, educated and made to believe that we could make a difference on every issue. During my presidency, I actively tried to put forth the ideas and suggestions made by the AMAA to lead the WVSMAA to the forefront.

I loved and enjoyed the confluences and annual conventions I attended in Chicago, and of course -- the shopping. The program ideas and information you can obtain from attending these meetings is overwhelming. In addition, the AMAA provided our state with a wonderful resource in field director Ann Wrenn, who was a guest speaker for our leadership confluence last fall in Charleston. She kept me very well informed of what needed to be done and how to most effectively focus my attention on the goals of the WVSMAA and the AMAA. She was always there, just a phone call away and I am very grateful to have had the chance to work with her.

Another valuable experience I gained from serving as president, was being able to visit other state confluences and conventions. I traveled to meetings in New Jersey, Pennsylvania and Ohio and learned a great deal about organizational skills, programming ideas, and what it takes to instill the interest in members to become leaders. I observed the respect and honor these other auxiliaries show toward their state auxiliaries and their officers, and I enjoyed the V.I.P. treatment that is accorded to a visiting auxiliary president. Most importantly, though, I came away from these visits realizing that although West Virginia is smaller, we still have the potential to have the same kind of successes in membership, health promotion, legislation, and AMA-ERF.

My travel to the various counties was always an adventure. I visited Martinsburg and I drove to Williamson twice -- on my first trip I made the mistake of taking the more mountainous route and I thought I would never reach my destination! I visited all the counties that invited me, and some I invited myself, but I really enjoyed sharing ideas and listening to the members. It is so rewarding to see the component auxiliaries in action.

The WVSMA headquarters is just like my second home, not only because I spent so much time there, but because of the staff. They were friendly, cooperative, and had a great attitude of partnership. When I was president-elect, I felt very comfortable working with Nancie Divvens, who acted as a temporary executive secretary. She shared my enthusiasm for trying to please the members and achieving the goals of the WVSMA and WVSMAA. George Rider, the executive director of the WVSMA, was always pleasant and ready to help. When Winnie Martin became our executive secretary in June, although she was young and new to the position, she learned very fast and was always eager to take on any new challenge. She has an extremely likeable personality and I enjoyed having her accompany me to the state confluences, conventions and to county meetings. Winnie introduced me to the West Virginia Coalition Against Domestic Violence and we attended and participated in discussions at their meetings with a variety of leaders from other associations and organizations. In addition, she also made me aware of the West Virginia Women's Commission and I was privileged to speak at several of their meetings about the Marriage Application Bill.

At the State Capitol, Winnie helped me meet legislators and gain their support for HB 2024. She also assisted me in editing my speeches, my letters and my reports. Her talents are many and the WVSMAA is sure to go forward under her direction -- especially when Carole Scaring takes the helm this month at the Annual Meeting.

I want to especially recognize WVSMA President Dr. Robert Pulliam. He was instrumental in every success that we achieved and believes strongly in the auxiliary's efforts on every level -- national, state and local. An old friend, Dr. Pulliam encouraged and invited me to go to county society meetings with him, and he has always given me the confidence and courage to do my best.

I have to recognize the media and their efforts in promoting HB 2024. Beckley Newspaper Editor Dan Page wrote dynamic editorials about our legislation; Tony O'Leary, a reporter provided good background information; and Bev Davis provided great coverage of the Raleigh County Medical Society and Auxiliary's Family Violence Forum. Also, the local TV and radio stations were a great help in our cause.

The support and encouragement I received from the AMAA, the WVSMA staff, the Raleigh County Medical Society, Dr. Pulliam, and my husband Dr. Salon, gave me the confidence I needed to put my ideas into motion. I am very proud of what the WVSMAA has accomplished this year, but I realize that the thanks goes to the members of the WVSMAA. Without your help and patience, we could not have gotten legislation passed; we would not have won an award for the highest increase in donations for AMA-ERF at the AMAA Annual Meeting in Chicago; and I would not feel as proud and confident as I do about becoming a leader. It has been a very gratifying year for me and I thank you for the honor of serving as your president.

Pacita Salon
WVSMAA President 1992-1993

West Virginia State Medical Association Alliance

"Physicians' Spouses Dedicated To The Health Of West Virginia"

Contact your local auxiliary/alliance or call
304/925-0342

Obituaries

J. Edward Jackson, M.D.

Dr. J. Edward Jackson, 81, who practiced family medicine in St. Albans for 39 years, died May 22 at home after a short illness.

A native of Freemansburg in Lewis County, Dr. Jackson received a B.S. degree from Morris Harvey College and his medical degree from Temple University in 1948. He interned at Charleston General Hospital and then opened his practice in St. Albans.

During his career, Dr. Jackson was on the medical staff of Thomas Memorial Hospital for 39 years, having served terms as chairman of the board of trustees and as chief of the medical staff. At the time of his death, Dr. Jackson was president of the Thomas Memorial Hospital Foundation and was president of the board of the Kanawha-Charleston Health Department.

Dr. Carl Tully, who is also a past president of Thomas' medical staff, said Dr. Jackson was devoted to family practice education, his patients and helping others.

"Dr. Jackson always supported medical education and helped many young doctors get started," Dr. Tully said. "He dedicated much of his life to helping his fellow man, patients, and the people of Kanawha County and surrounding areas."

In 1977, Dr. Jackson was named the Doctor of the Year by the West Virginia Chapter of the American Academy of Family Physicians. He was a past president of Kanawha County Medical Society and had been a member of the WVSMA since 1949. A veteran of the Air Force, Dr. Jackson was also a member of Highlawn Baptist Church, Charleston Masonic Lodge 153, Scottish Rite Bodies, Beni Kedem Shrine, the Royal Order of Jesters and Kanawha Country Club.

Dr. Jackson is survived by his wife, Ann Sutherland Jackson; sons, Lt. Gen. John E. Jackson Jr. of Riverside, Calif., and Thomas F. Jackson of Charleston; brother, Afton of Charleston; two grandchildren; and one great-granddaughter.

Nicholas D. Zambos, M.D.

Dr. Nicholas D. Zambos, 78, of Beckley, died July 1, in a Beckley hospital following a short illness.

Born July 17, 1914, in Athens, Greece, Dr. Zambos received his medical degree from the University of Athens. He then served with the Greek Expeditionary Forces in Korea and Japan from 1949 to 1952.

In 1952, Dr. Zambos came to the United States to serve an internship at James Walker Memorial Hospital in Wilmington, N.C. He also served internships at Charlotte (N.C.) Memorial Hospital and the Shriners' Hospital for Crippled Children in Lexington, Ky. Dr. Zambos graduated from the four-year orthopedic residency program at Duke University Medical School in Durham, N.C.

Dr. Zambos moved to Beckley in 1958 and was associated with the Southern West Virginia Clinic. He opened his medical practice, the Beckley Orthopedic Clinic, in 1970 and operated it until his retirement in November 1992.

In addition to being a member of the WVSMA, Dr. Zambos was a member of the AMA, the Southern Medical Association and the Raleigh County Medical Society. He was also a member of the Beckley Rotary Club, the Beckley Elks Club and Black Knight Country Club.

Dr. Zambos was preceded in death by a brother and two sisters.

Survivors include his wife, Joyce Purvis Zambos; four sons, Dennis of Lakeland, Fla., Dr. Philip of Ashland, Ky., Dr. John of Titusville, Fla. and Tony of North Palm Beach, Fla.; a daughter, Alexandra of Asheville, N.C.; a sister, Niovi Zambos Sotiriades of Athens; and three grandchildren.

Donations of sympathy may be made to the Dr. Nicholas Zambos Memorial Fund at the Beckley Area Foundation, P.O. Box 1575, Beckley, W.Va. 25802-1575.

A GIFT that remembers... by helping others to live

When you lose someone dear to you — or when a special person has a birthday, quits smoking, or has some other occasion to celebrate — memorial gifts or tribute gifts made for them to your Lung Association help prevent lung disease and improve the care of those suffering from it.

AMERICAN LUNG ASSOCIATION®
The Christmas Seal People®

Make a contribution to life after death.

THE AMERICAN HEART ASSOCIATION MEMORIAL PROGRAM®

American Heart Association

This space provided as a public service.

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article
1993 West Virginia family practice residents: Demographics and future plans 378

Scientific Newsfront
Management of residual squamous intraepithelial lesions of the cervix after conization 382
Competency assessment in the elderly 386
Manuscript Guidelines 388
Hepatitis B surface antigen prevalence in blood samples tested at Cabell Huntington Hospital 389

President's Page
Communication: A two-way street 392

Editorial
Know the law regarding the new DNR Act! 394

In My Opinion
Doctors and the Legislature 395

Special Departments
General News 398
Continuing Medical Education 402
Medical Meetings/Poetry Corner 403
Bureau of Public Health News 406
Robert C. Byrd Health Sciences Center News 408
Marshall University School of Medicine News 410
Medical Student News 412
Obituaries 414
Classified 417
September Advertisers 418

Front Cover

Teasel silhouetted against a spectacular sunset in Mullens, W.Va. Photo courtesy of *Scott Durham* of Pineville, W.Va.

1993 West Virginia family practice residents: Demographics and future plans

STEPHEN L. SEBERT, M.D.
Associate Professor of Family Medicine, WVU School of Medicine, Morgantown

Abstract

To call attention to the concerns of the 92 family practice residents in the five programs in West Virginia and assist with their retention, a questionnaire was mailed to these physicians. The questions asked concerned their home states, future plans, educational debts, salary expectations, recruiting preferences, and their suggestions on how to interest more medical students into this specialty. The responses to the survey provided valuable information regarding how to improve retention of family practice residents in the state, as well as increase the number of medical students entering family medicine. In addition, the survey showed the Bureau of Public Health, the Kellogg Program and the Rural Health Initiative Program are not as effective as they could be in recruiting family practice residents to practice in underserved areas of the state.

Introduction

Health care reform is one of this year's most controversial topics. There are multiple proposals, but most call for more emphasis on primary care and more family practitioners, particularly in rural areas. Most authorities agree that a higher percentage of medical school graduates need to be going into family practice residencies (1); and many articles have been written to explain why medical students select family practice as a specialty (2,3,4), and also why they locate in rural communities (5,6).

In order to learn more about current family practice residents in West Virginia, a questionnaire was sent to all of the physicians in the five programs in the state. The questions asked concerned their home states, future plans, educational debts, salary expectations, recruiting preferences, and their suggestions for recruiting more medical students into family practice.

Methods

To learn specific demographics of all 92 family practice residents in West Virginia and their future plans for practice, a survey was developed and mailed to these physicians at West Virginia University in Morgantown, Marshall University in Huntington, and the community hospital-based programs in Charleston, Wheeling and Clarksburg.

The survey was sent to the residents in January 1993 and a follow-up letter was sent in March 1993. It was designed to elicit responses which indicate future plans and locations and identify variables that may impact on these decisions. Before the survey was mailed, it was reviewed and slightly modified by faculty members of the WVU Family Medicine Department.

Results

Of the 92 family practice residents in West Virginia, 68 (74%) responded. Table 1 shows respondents according to their year of residency and the program where they are residents.

The responses indicated that 42 (62%) of the respondents were from West Virginia. One resident was from Egypt and the others were from Pennsylvania, Kentucky, California, Texas, Ohio, Washington, Arkansas, New York, Oregon, Maryland, Indiana, Iowa, Tennessee, Georgia and Illinois.

Forty-eight (71%) of the residents indicated that they were married while 17 (25%) said they were single. Of the married residents, 38 stated that their spouses are agreeable to staying in West Virginia and five (10%) said their spouses were not willing to remain in the state. Twenty of the residents questioned had spouses whose occupations are a consideration in where they locate, and 23 said that this was not a factor in where they would practice.

In regards to the debts the residents had incurred, 19 (28%) of those responding said they have no debt excluding automobiles and real estate.

TABLE 1. Respondents according to their family practice program and year of residency.

Program	First-Year Residents	Second-Year Residents	Third-Year Residents	Totals
Clarksburg	5 (5)	7 (8)	5 (6)	17 (19)
Wheeling	4 (5)	3 (5)	2 (4)	9 (14)
Marshall	3 (10)	5 (7)	5 (9)	13 (26)
Charleston	3 (5)	4 (4)	5 (5)	12 (14)
WVU	6 (6)	4 (4)	7 (9)	17 (19)
Totals	21 (31)	18 (28)	24 (33)	68 (92)

The number in front of the ( ) indicates number of responses.
The number in the ( ) indicates the total number of residents in that program.

TABLE 2. The Practice Plans of Current Family Practice Residents

Small Group Practice in West Virginia	2
Medical Clinic in West Virginia	5
Private Practice in West Virginia	8
Faculty at West Virginia University	1
Emergency Room in West Virginia	1
Student Health at West Virginia University	1
Urgent Care Center in West Virginia	1
Number of Residents Planning to Remain in the State	19
Urgent Care Center in Michigan	1
Private Practice in North Carolina	3
Group Practice in Ohio	1
Private Practice in Missouri	1
Private Practice/Director of Sports Medicine in Ohio	1
Emergency Medicine Fellowship	1
Private Practice in Tennessee	2
Private Practice in Colorado	1
Anesthesiology Residency	1
Indian Health Service	1
Number of Residents Planning to Leave the State	13

The rest have unsecured debts ranging from $3,000 to $200,000. The average unsecured indebtedness of the 68 residents is $35,000.

The first-year incomes which the residents stated they expected ranged from between $40,000 and $150,000, and the average expected first-year income was $91,700 - $100,080. Many of the respondents indicated a range of income and these are the means of the extremes or the ranges.

Thirty-four residents (50%) know what they will do after residency, and the other 31 (46%) were undecided. Of those who have decided, 11 (32%) said they would be leaving West Virginia, and 23 (68%) plan to stay in the state. The majority decided where they were going in the second or third year of their residency and their plans are shown in Table 2.

The most important factors the residents cited in deciding were to practice were:

(1) A desirable geographic location
(2) Being close to family
(3) The practice situation
(4) Lifestyle and time with family
(5) Reimbursement and incentives
(6) The economy
(7) Spouse's job; and
(8) The need for primary care.

Factors that characterize ideal practice situations for the residents included: salaried jobs, scheduled vacation, retirement plans, good place to live, group practice or HMO, reasonable call, loan repayment plans, and reimbursement. Only 27 residents (40%) indicated that there has been an effort to keep them in West Virginia. Of these residents, 24 (88%) said the recruiting effort was not very vigorous or useless. Only six (22%) think the recruiting effort was reasonable.

The ways in which the residents would like to be recruited included being taken out to dinner to discuss practice opportunities, receiving letters with booklets of local information and simple, straightforward information, attending a recruitment fair, or through a loan repayment program. In addition, some of the residents stated they would be more apt to be recruited to stay in West Virginia if state government and agencies reflected a more progressive attitude toward health maintenance, and others stated they did not like a hard sell approach and professional recruiters.

The residents answering the questionnaire mentioned they liked recreational activities and were concerned about their children's educations. They gave the following factors as the items they would like to have if they would practice in West Virginia:

(1) A very good salary
(2) A reasonable call schedule
(3) A happy spouse
(4) A loan repayment program
(5) Low professional liability insurance premiums
(6) A group practice or good backup; and
(7) Job opportunities for their spouse.

Fifteen of the residents (22%) plan to perform obstetrics while 38 do not. Eight said they felt "OK" about mid-level providers, and nine said they are essential. One resident was worried about mid-level providers taking family practice jobs, but most of the respondents had little or no experience with them.

The Kellogg Community Partners Plan and the Rural Health Initiative (RHI) were not understood by 37 (54%) of the residents questioned, and only 19 residents had somewhat of an understanding of the role of these two programs. Only 8 (12%) of the residents had involvement with either the Kellogg or RHI programs, and 13 (19%) feel these programs will not influence medical students to go into family practice, while 15 (22%) said these programs will influence medical students to go into family practice.

When asked about their suggestions to increase the number of family physicians in West Virginia, the residents responses included the following comments:

"Begin early and be frank about community practice expectations."
"Better schools and economic climate."
"Make the state a better place to live."
"Financial incentives and increased reimbursements."
"Loan repayment."
"Increased respect."
"Select med school candidates interested in FP."
"Rural faculty positions."
"Rural rotations for residents."
"Try to set up more group practices."
"Recruit medical students from underserved areas."
"The state has to get serious about public policy and insurance reform."

In addition, some of their suggestions for getting medical students to enter family medicine were:

"Expose them to FP mentors early."
"More involvement with family doctors in community settings."

"More 4th-year rotations with family doctors."

"Equitable pay compared to other specialties."

"Put quotas on the number allowed to go into specialties."

"Increase exposure to options available to family medicine, i.e. fellowships."

"Increased respect from other services."

"Strong networking and support for the rural family doctors and good reimbursement."

"More emphasis on teaching and less on evaluation."

"More non-traditional students."

"Med school faculty must validate importance of family practice."

"Bidirectional respect."

"Community rotations to expose students to family practice outside of the academic ivory-tower setting."

"More lectures to medical students by family practitioners."

Discussion

The results of this survey indicate that the majority (62%) of the 92 family practice residents in residencies in West Virginia are natives of the state. Only half of them have decided what they are going to do after residency. Of the 34 residents who have already made future plans, 11 will be leaving the state. This indicates that there is a large pool of future family doctors who could be recruited to practice in undeserved areas of West Virginia, but there has not been an effective effort to recruit them.

Although there is no consensus as to what type of practice they will do or what factors will determine where they choose to locate, living near family, call schedule, backup, and lifestyle issues are very important to these residents. These "controllable lifestyle factors" are well documented in the literature (4). The majority feel there have been suboptimal efforts to keep them in West Virginia and they would like to have low pressure information about practice opportunities.

Reimbursement and other incentives as well as lifestyle considerations are important in recruiting residents to rural areas. Since the study shows that the state's five residency programs are fertile hunting grounds for family doctors, the best way to recruit them is for physicians looking for an associate to visit the residency programs nearest them to meet with the second and third-year residents.

The literature also shows that family practice residency faculty members have a great influence on where residents choose to practice (5). However, there appears to be little evidence that faculty members are encouraging residents to practice in West Virginia. This seems to indicate that there needs to be more collaboration between communities and practicing physicians who are looking for family physicians and the faculty members of the residency programs.

In addition, the study showed that most residents do not plan to provide obstetrical care, nor do many of them have an understanding of either the Kellogg Community Partners Program or the Rural Health Initiatives Program. The vote is split on whether the family practice residents think these programs will influence medical students into this specialty. The study determined that more exposure to family physicians and equitable pay with specialists are the best ways to recruit medical students to enter family practice medicine.

Conclusions

The findings of this study suggest that more emphasis should be placed on exposing medical students to successful family practice physicians through community rotations. It also showed that the medical schools should use their influence to improve reimbursement and respect for primary care physicians.

A better effort should be made to inform residents about practice opportunities in West Virginia, which can be done primarily by improving the communication between the residency programs and the practicing physician community. The West Virginia Bureau of Public Health does not appear to be effective in its efforts to recruit these residents to practice in undeserved areas of the state. The Kellogg and RHI programs are also doing a poor job of involving residents and seem to be ignoring the most immediate source of family physicians.

Many of the residents expressed their gratitude for a chance to voice their opinions regarding recruitment and retention of family physicians. They appear to feel they are being left out of the decision-making process involving health care reform issues. Hopefully, this paper will call attention to the concerns of the state's family practice residents and facilitate their retention in West Virginia.

References

1. Rosenblatt RA. Confronting the millennium: family medicine in the late 20th century. Department of Family Medicine, University of Washington, School of Medicine, Seattle. Fam Med 1990 Jan-Feb;22(1):46-51.
2. Garrett EA, Dietrich AJ. Students' evolving attitudes toward family medicine and specialty choices at one medical school. Department of Family and Community Medicine, University of Missouri-Columbia School of Medicine. Acad Med 1991 Oct;66 (10):625-7.
3. Rucker L, Morgan C, Ward KE, Bell BM. Impact of an ambulatory care clerkship on the attitudes of students from five classes (1985-1989) toward primary care. Department of Medicine, Bronx Municipal Hospital, New York. Acad Med 1991 Oct;66(10):620-2.
4. Schwartz RW, Haley JV, Williams C, Jarecky RK, et al. The controllable lifestyle factor on students' attitudes about specialty selection. Department of Surgery, University of Kentucky College of Medicine, Lexington. Acad Med 1990 Mar;65(3):207-10.
5. Riley K, Myers W, Schneeweiss R. Recruiting physicians to rural practice: suggestions for success. Department of Medical Education, University of Washington School of Medicine, Seattle. West J Med 1991 Nov;155(5);500-4.
6. Brazeau NK, Potts MJ, Hickner JM. The Upper Peninsula Program: a successful model for increasing primary care physicians in rural areas. Upper Peninsula Campus of Michigan State University College of Human Medicine, Escanaba. Fam Med 1990 Sept-Oct;22 (5);350-5.

Discover The Elegance Of A Hybrid

At first glance, it's the ***beauty*** of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its ***elegance*** becomes apparent—a gentle blend of softness and strength.

At first glance, it's the ***enhanced performance*** of Vaseretic that catches the eye. But study Vaseretic more closely, and its ***elegance*** becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid ***blending of tolerability and power*** that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

VASERETIC® 10-25 *Next*

Enalapril Maleate-Hydrochlorothiazide

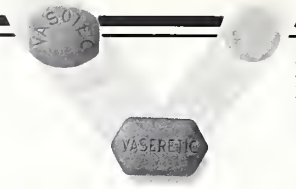
Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

TABLETS
VASERETIC®
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality*.



10 mg

25 mg

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General; Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions*, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide*).

Pregnancy; Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality*, below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC® should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5. 6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General; Enalapril Maleate; Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions.*)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium*).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients; Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions; Enalapril Maleate; Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide; When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Cholestyramine and colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively. Thiazides may be administered two to four hours before the resin when the two drugs are used concomitantly.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

* Registered trademark of Hospal Ltd.

Vaseretic® is a registered trademark of Merck & Co., Inc.

Manufactured by Merck & Co., Inc.

© 1993 DuPont Pharma

Printed in USA

bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy; Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other:* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough.*

Clinical Laboratory Test Findings; Serum Electrolytes: See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular:* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression, a few cases of hemolysis in patients with G-6-PD deficiency have been reported in which a causal relationship to enalapril cannot be excluded; *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticana, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses:* Transient blurred vision, xanthopsia.

* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

Dist. by

MERCK & CO., INC.
West Point, PA 19486, USA

Issued October 1992
7432317

Printed in USA

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

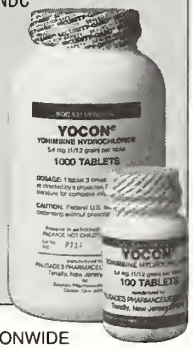
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
64 North Summit Street
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Management of residual squamous intraepithelial lesions of the cervix after conization

CURTIS D. WHITE, M.D.
WARREN L. COOPER, M.D.
RODNEY R. WILLIAMS, M.D.
Department of Obstetrics and Gynecology, Marietta Memorial Hospital, Marietta, Ohio

Abstract

From January 1985 to October 1992, 158 conizations of the cervix were performed for squamous intraepithelial lesions (SIL) of the cervix. Thirty-one (20.4%) of these cases had disease extending to the margins of resection. The majority (60.7%) had spontaneous resolution of disease. Conservative follow-up aided by the body's own immune system may allow an even greater percentage to resolve spontaneously. Smoking presents an added factor for persistent as well as recurrent disease.

Introduction

Colposcopic evaluation often allows complete evaluation and treatment of the abnormal pap smear on an outpatient basis. Conservative management such as excisional biopsy, cautery, cryosurgery, and laser has significantly diminished the need for surgical conization of the cervix. While LEETZ may further limit the need for surgical conization, under certain conditions it is still indicated (1).

Even with proper technique, squamous intraepithelial lesions (SIL) may extend to the margins of resection in 20% to 69% of cases on pathologic analysis (1,2). These patients may be at risk for persistent SIL that can progress or may already have a more advanced lesion that goes undiagnosed. While some patients are followed conservatively with pap smears, often they are subjected to additional surgery such as a second conization or hysterectomy to treat any residual disease.

The majority of patients with disease extending to the margins of resection will have spontaneous resolution of residual disease possibly influenced by the immune response and the inflammatory response of healing after cone biopsy (1,3,4,5). Other co-factors such as the severity of disease as well as smoking have been reported to influence resolution of disease (6-9).

The purpose of this study is to review retrospectively those cases of SIL extending to the margins of resection after conization of the cervix and make recommendations for optimal management of residual disease.

Materials and methods

All patients in the authors' practice undergoing colposcopic evaluation for an abnormal pap smear from January 1985 to October 1992 were reviewed. Of these, 151 patients underwent 158 conizations of the cervix, with the technique previously described (1).

The entire specimen was submitted for review to the Department of Pathology at Marietta Memorial Hospital. Four to seven sections were evaluated from each quadrant. Patients with clear margins of resection were followed with pap smears every three months for one year and annually thereafter if they remained negative. Patients with positive margins of resection were followed either with pap smears, repeat conization or hysterectomy.

Five patients with invasive disease were managed appropriately according to stage and are not included in this study. One patient with adenomatous hyperplasia of the endocervix is also excluded. All patient records were reviewed for identifying data, histology, age, parity and history of smoking.

Results

Of the patients having SIL, the reasons for the conizations are listed in Table 1. The majority of these procedures were performed because of unsatisfactory colposcopy, with the second most common indication being extensive disease followed by unexplained pap smear, positive endocervical curettage, treatment failure, suspicion of microinvasive disease, and finally abnormal endocervical cells.

The histopathologic distribution of the 152 conizations performed in 145 patients is listed in Table 2. There were 29 conization specimens with low-grade SIL, and 123 with high-grade SIL. The patients' ages ranged from 18 years to 70 years, with a mean of 34.2 years. Of the 152 conizations, 31 (20.4%) had disease extending to the margins of resection. Two had a positive margin on the ectocervix, 28 had a positive endocervical margin, and one had both. Their ages ranged from 21 years to 69 years, with a mean of 34.8. Negative margins were found in 121 cases (79.6%) with ages

TABLE 1. Reasons for Conization of the Cervix

	Number of Cone Biopsies
Positive ECC	14 (9.2%)
Unsatisfactory Colposcopy	67 (44%)
Unexplained Pap Smear	25 (16.4%)
Extensive High-Grade SIL	30 (19.5%)
Treatment Failure	12 (7.9%)
Suspicion of Microinvasive Disease	3 (2%)
Pap Suggestive of Atypical Endocervical Cells	1 (1%)
Total	152 (100%)

TABLE 2. Histopathologic Distribution of 158 Conizations Performed in 151 Patients

	#	%
Low-Grade SIL	29	19.1%
High-Grade SIL	123	80.9%
Total	152	100%

TABLE 3. Positive Margins in Conization for SIL

	Positive Margins	Negative Margins	Total Number
Number of Cases	31 (20.4%)	121 (79.6%)	152
Age	21-69 (x = 34.8)	18-67 (x = 34)	

TABLE 4. Histopathologic Distribution of Conization Specimens with Positive and Negative Margins

	Number of Patients with Negative Margins	Number of Patients with Positive Margins
Low-Grade SIL	28 (23.1%)	1 (3.2%)
High-Grade SIL	93 (76.9%)	30 (96.8%)
Total	121 (100%)	31 (100%)

TABLE 5. Resolution in Follow-up of SIL Extending to the Margins of Resection

	Positive Residual SIL	Negative Residual SIL	Total
Pap Smears	3 (18.8%)	13 (81.2%)	16
Hysterectomy	7 (63.6%)	4 (36.4%)	11
Repeat Conization	1	0	1
Lost to Follow-up			3
Total	11	17	31

TABLE 6. Recurrent Persistent SIL After Conization

Total Cone Biopsies	153
Recurrent SIL in 121 Conizations with Negative Margins	13
Persistent SIL in 31 Conizations with Positive Margins	11

ranging from 18 years to 67 years (mean 34) (Table 3).

The histopathologic distribution of the 31 cone biopsies with SIL extending to the margins, as well as the 121 with negative margins, are listed in Table 4. Of those with clear margins of resection, 93 (76.9%) were high-grade SIL. In those with positive margins of resection, 30 (96.8%) were high-grade SIL. There was a significantly greater percentage of patients with high-grade SIL in those having positive margins of resection ($p = .024$).

The follow-up and residual disease of the 31 patients with SIL extending to the margins of resection is outlined in Table 5. Sixteen were followed with pap smears, 12 for more than one year. Three of these showed persistent SIL. Eleven were treated with hysterectomy for various other benign gynecologic conditions, as well as for patient anxiety regarding persistent cervical disease in some cases. The hysterectomies were performed from one to eight weeks after conization of the cervix and seven of these patients had persistent SIL. One patient had a repeat conization showing residual SIL within one month of the first conization. Three patients were lost to follow-up. Overall, 17 of the 28 patients (60.7%) had spontaneous resolution of the disease. The overall persistence rate of those with follow-up was 11 or 149 = 7.4%.

Of the 11 cases with positive margins of resection and persistent SIL in follow-up (three followed by pap, seven with hysterectomy, one with repeat conization), all had high-grade SIL on conization. Of the 121 patients with negative margins of resection, 13 (10.7%) developed recurrent SIL from one to six years later. All 11 patients had high-grade SIL (Table 6).

Smoking

The association of smoking was also evaluated in this study. Of the 145 patients with SIL, 65 (44.8%) smoked an average of 0.5 - 2.5 packs per day. Seventy-eight (53.8%) were non-smokers and two patients (1.4%) did not have histories recorded (Table 7).

These results compare with an 18% frequency of smoking in the general female population in our practice without SIL ($p = < .0001$). The average age of those who smoked was 29.6 years compared to 37.8 years of those who did not smoke ($p = < .0001$).

Of the 31 patients who had positive margins of resection and SIL, 14 (45.2%) were smokers compared to 17 (54.8%) who were not. In addition, of the 121 patients with negative margins, 56 (46.3%) were known smokers, 63 (52.1%) were not smokers, and information on the other two patients was not available (Table 8). While the overall number of smokers in those with SIL is greater than in the general population, there was no significant difference in those with positive or negative margins in this study.

Table 9 provides a breakdown of the distribution of conization specimens according to the patients' smoking status. Of the patients followed conservatively with pap smears, two out of three (66.7%) smokers had persistent disease, whereas in only one of the 13 (7.7%) non-smokers did this happen ($p = .071$). While this was not statistically significant due to the small number of patients studied, it suggests that with a larger sample size it could be considerable.

Of the patients followed with hysterectomy, five of seven (71.4%) who smoked had residual SIL in the hysterectomy specimen compared to three of four (75%) of non-smokers who had residual SIL. There was no significant difference between the two hysterectomy groups; and the one patient who had a repeat conization had residual disease and was a smoker.

Of the 121 patients with negative margins of resection, 13 (10.7%) developed recurrent SIL in follow-up of one to six years. Ten (76.9%) of these were smokers compared to three (23.1%) who were not. In one, smoking history was not available. The risk of recurrent disease was

TABLE 7. Distribution of Smokers and Patients Having Cone Biopsies with SIL

Smokers	65 (44.8%)
Non-Smokers	78 (53.8%)
History Unknown	2 (1.4%)
Total	145 (100%)

TABLE 8. Incidence of Smoking After Cone Biopsy for SIL

Positive Margins in Cone Biopsy for SIL
14 (45.2%) Smokers
17 (54.8%) Non-Smokers

Negative Margins in Cone Biopsy for SIL
56 (46.3%) Smokers
63 (52.1%) Non-Smokers
2 (1.6%) Unknown Smoking History

TABLE 9. Distribution of SIL and Smoking

	Number of Patients with Negative Margins	Number of Patients with Positive Margins
Smoking		
Low-Grade SIL	10 (8.3%)	0 (0%)
High-Grade SIL	46 (38%)	14 (45.2%)
Non-Smoking		
Low-Grade SIL	18 (14.9%)	1 (3.2%)
High-Grade SIL	45 (37.2%)	16 (51.6%)
Smoking History Unknown		
Low-Grade SIL	0 (0%)	
High-Grade SIL	2 (1.6%)	

significantly higher for smokers ($p = .000006$).

Discussion

With the use of colposcopy and biopsy, as well as other conservative outpatient measures for treatment such as cautery, cryosurgery, laser, and LEETZ, the need for surgical conization of the cervix has diminished. However, it still remains an important part of the evaluation and treatment of the abnormal pap smear (1).

Hysterectomy used to be considered the appropriate treatment for CIN, especially CIN III (5). When the conization procedure has completely excised all the SIL with no disease extending to the margins of resection, cure rates are comparable to hysterectomy (10,11). Recurrences can still occur, therefore, continued follow-up is mandatory (1,3,10).

The incidence of residual cervical dysplasia after conization has been reported to be from 20% to 69% (1,2). Involvement of the margins of resection with SIL after conization is associated with increased risks of persistent disease and decreased cures (1,2,10,12,13). Factors reportedly associated with positive margins of resection include the number of sections made by the pathologist, severity and extent of the SIL, and whether the woman smokes cigarettes.

However, several authors have noted a decrease in the predicted versus actual residual disease in those patients with SIL extending to the margins. VanNagell Jr. reported a 20% to 29% incidence of residual dysplasia in the cervix after conization, but a recurrence rate of only 3.2% - 13% (14). White reported an overall persistence rate of 9.1% - 20.2% with positive margins of resection (1).

In 1960, Shulman and Cavanaugh suggested that excision of the major portion of the abnormal epithelium aided the body in destroying the remaining neoplastic cells (15). In 1963, Koss reported that the inflammatory reaction resulted in dislodging fragments of residual dysplasia with subsequent reformation of the surface by healthier epithelium (16). In 1966, Richart suggested that cervical biopsy could eradicate cervical CIN indirectly by altering the balance between the host and the neoplasm (17).

Other authors have similarly implicated the immune system by suggesting that the inflammatory response of healing after conization may play a role in obliterating minimal residual disease in the cervix (1,3,4,5). A direct association between the number of inflammatory cells in the cervix and spontaneous resolution of residual SIL after conization of the cervix has been reported (18).

Systemic immunosuppression has been implicated in the development of SIL and carcinoma of the cervix. The immune response involved in the resolution of residual disease appears to be more of a local reaction in the cervix (19).

Smoking has previously been reported as a risk factor for the development of cervical cancer and CIN, as well for recurrence of disease after treatment (6,7,8,9). In our series, the incidence of smoking among the patients undergoing conization for SIL was 44.8%, a significantly greater amount than the number of smokers without SIL in the general population and in our area (18%).

The difference in smoking was not significant between those that had disease extending to the margins of resection and those with clear margins. However, smoking probably has a negative effect on the spontaneous resolution of residual disease (disease extending to the margins of resection). Follow-up pap smears revealed that two out of the three (66.7%) patients who smoked had residual disease, compared to 1 out of 3 (7.7%) of the non-smokers in the study. While this did not reach statistical significance ($p = .071$), this may have been limited by small sample size. The difference in those followed by hysterectomy was not so striking because only five out of seven (71.4%) who smoked had residual SIL in the hysterectomy specimen compared to three out of four (75%) non-smokers who had residual SIL. The one patient who had a repeat cone biopsy had residual disease and was a smoker.

As previously discussed, the inflammatory response of healing after cone biopsy has a role in eliminating residual SIL. In patients followed conservatively with pap smears, this allows time for the body's local immune response to play a role. It is suggested that given more time between conization and hysterectomy, there could be less residual disease in the specimen because of this affect. Overall, 17 out of 28 (60.7%) had spontaneous resolution of disease.

Due to the risk of recurrent disease in negative margins of resection, especially in smokers, continued follow-up is important (1). Recurrent disease was noted in 13 of 121 patients with negative margins (10.7%). Ten (76.9%) of these women were smokers, three (23.1%) were not, and a smoking history was not available in the other patient.

Conclusions

Recurrent SIL may be secondary to undiagnosed multifocal disease from the start, inadequate sectioning of the conization specimen with undiagnosed positive margins or due to true recurrent disease possibly from continued exposure to carcinogenic stimuli, such as the human papillomavirus.

Conization in many cases offers adequate treatment for SIL. In patients with disease extending to the margins of resection, there is a possible risk of more significant disease going undiagnosed. However, in the majority of cases, spontaneous resolution of residual disease likely can be expected in time. Unless other indications for hysterectomy exist, pap smear follow-up is suggested for at least six months to allow further resolution or to confirm persistent disease.

Discontinuation of smoking may play a valuable role in enhancing resolution of disease as well as decreasing the risk of recurrence. In the patient who is unable to quit smoking, more aggressive treatment might be considered earlier when there is a positive margin of resection. Due to the possibility of recurrent SIL, even after complete excision, continued follow-up including regular pap smears is indicated.

References

1. White CD, Cooper WL, Williams RR. Cervical intraepithelial neoplasia extending to the margins of resection in conization of the cervix. J Reprod Med 1991;36:635.
2. Paterson - Brown S, Chappatteo A, Clark SK, et al. The significance of cone biopsy resection margins. Gynecol Oncol 1992; 46:182.
3. VanNagell JR Jr, Parker JC, Hicks IP, et al. Diagnosis and therapeutic efficiency of cervical conization. Am J Obstet Gynecol 1976;124:134.
4. VanNagell JR Jr, Roddick JW, Cooper RM, et al. Vaginal hysterectomy following conization in the treatment of carcinoma in situ of the cervix. Am J Obstet Gynecol 1972;113:948.
5. Creasman WT, Rutledge F. Carcinoma in situ of the cervix: an analysis of 861 patients. Obstet Gynecol 1972;39:373.
6. Nischan P, Ebeling K, Sindler C. Smoking and invasive cervical cancer risk: results from a case control study. Am J Epidemiol 1988;128:74.
7. Hellberg D, Nilsson S, Haley NJ, et al. Smoking and cervical intraepithelial neoplasia: nicotine and continine in serum and cervical mucous in smokers and non-smokers. Am J Obstet Gynecol 1988;158:910.
8. La Vecchia C, Franceschi S, Decault A, et al. Cigarette smoking and the risk of cervical neoplasia. Am J Epidemiol 1986;123:22.
9. Grail A, Norval M. Significance of smoking and detection of serum antibodies to cytomegalovirus in cervical dysplasia. Br J Obstet Gynaecol 1988;95:1103.
10. Ahlgren M, Ingemarsson I, Lindberg LG, et al. Conization as treatment of carcinoma in situ of the uterine cervix. Obstet Gynecol 1975;46:135.
11. Linasmita V. Cervical intraepithelial neoplasia: the predictability of residual disease in the uterus from microscopic study of cone biopsy margins. J Med Assoc Thai 1988;71:122.
12. Gerard N, Moritz J, Kowalik A, et al. Human papillomavirus types and cervical squamous intraepithelial lesions that recur after cold-knife conization. Gynecol Oncol 1992;46:304.
13. Bjerre B, Eliasson G, Linell F, et al. Conization as only treatment of carcinoma in situ of the uterine cervix. Am J Obstet Gynecol 1976;125:143.
14. VanNagell JR Jr, Gary EC, Powell DF. Cervical intraepithelial neoplasia. In: JR VanNagell Jr., HRK Barker, Littleton MA, John Wright PSG, editors. 1982:21-57.
15. Schulman H, Cavanaugh D. Intraepthelial carcinoma of the cervix: the predictability of residual carcinoma in the uterus from microscopic study of the margins of the cone biopsy specimen. Cancer 1961;14:795.
16. Koss LG, Stewart FW, Foote FW, et al. Some histologic aspects of behavior of epidermal carcinoma in situ and related lesions of the uterine cervix. Cancer 1963;16:1160.
17. Richart RM. Influence of diagnostic and therapeutic procedures on the distribution of cervical intraepithelial neoplasia. Cancer 1966;19:1635.
18. White CD, Macatol FR, DeJosef AB. Inflammatory cell infiltrate in the cervix as a predictor of residual cervical intraepithelial neoplasia after conization. J Reprod Med 1992;37:799.
19. Hawthorn RJ, Murdoch JB, MacLean AB, et al. Langerhans' cells and subtypes of human papillomavirus in cervical intraepithelial neoplasia. Br Med J 1988;297:643.

Easter Seals making a difference in the lives of West Virginians with disabilities

Two of the many services we provide include:

* State information and referral program connecting individuals with disabilities to appropriate agencies and professionals.
* State assistance program providing up to $100 for persons with documented needs to use toward evaluations, therapy and equipment.

For more information, contact:

Easter Seal Rehabilitation Center
1305 National Road
Wheeling, WV 26003
(304) 242-1390 Voice or TDD (304) 242-1390 or (800) 677-1390

Competency assessment in the elderly

M. KHALID HASAN, M.D., F.A.P.A., F.R.C.P.(C), M.R.C. PSYCH (U.K.)
Diplomate, American Board of Psychiatry and Neurology; Diplomate, Geriatric Psychiatry; Associate Clinical Professor, West Virginia University; Chairman, Department of Psychiatry, Beckley Appalachian Regional Healthcare; and Staff Physician, Raleigh Psychiatric Services, Inc., Beckley

DREAMA GAIL BAKER, M.A.
Licensed Clinical Psychologist, Raleigh Psychiatric Services, Inc.; and Chief, Psychology Division of Department of Psychiatry, Beckley Appalachian Regional Healthcare, Beckley

Abstract

Although brain changes and functional capacity impairment occur in both normal and abnormal aging, it is the extent of change which determines competency status. Dementia to some degree afflicts 10 percent to 15 percent of 30 million Americans over age 65. History, age-normed neuropsychological testing, and laboratory investigations are essential to competency assessment since physical and personality dysfunctions may masquerade as dementia. Since competency decisions profoundly impact the lives of the elderly, our fastest growing segment of national population, psychiatrists, psychologists, family physicians, and lawyers will become increasingly involved in competency issues.

Introduction

Currently, 12 percent of the population is age 65 and over, and the fastest growing segment is individuals over the age of 80. Of the approximately 30 million people over age 65, five percent have severe dementia, 15 percent are mildly impaired, and in the group over 85, nearly half show some degree of cognitive impairment.

"Competency" is defined as the cognitive ability of an individual to know and understand the nature and consequences of legal proceedings in which he/she may be involved, or the medical situations confronting him/her (1). There are deep pervasive emotional, experiential and economic problems of a disheartening nature affecting psychiatric involvement in the care of the elderly person with multiple disabilities. Yet, the need for competency assessment continues to grow for medical, social, legal and economic reasons (2,3).

Normal and pathological aging

Significant biological changes occur at different rates in various organs with age. Although response to stress on the system may become compromised, in the absence of significant chronic disease functional independence including cognitive function remains intact even up to the ninth decade, though retrieval and recall may be slowed. Fluid intelligence, i.e. flexibility of thinking, adaptability to new input and perception of relationships between concepts is diminished, motor speed and coordination suffer, and visuo-spatial tasks are performed less efficiently whether timed or untimed.

Recent memory declines are nearly ubiquitous in the elderly. On the other hand, "crystallized intelligence" or knowledge acquired in the course of socialization (e.g. comprehension of communication, incorporation of values and wisdom) tend not only to remain stable, but to increase as cumulative assets of longevity and experience (4). Therefore, it is necessary for the psychiatrist and psychologist team to differentiate among age-associated memory impairment (benign senescence), depression, and other disorders masquerading as dementias (medical, transient confusion states, delirium or other reversible dementias such as drug or alcohol intoxication). Fundamental to competency assessment are detailed history-taking, laboratory investigations, and neuropsychological testing to ascertain the presence and severity of dementia and to safeguard the legal rights of the patient.

Since patient history is fundamental, it must be done with care. It is vital that the psychiatrist/psychologist team spend time to establish a rapport with the patient in order to develop an environment in which the patient will be receptive to communication and information. Since dementia is acquired, premorbid education and vocational attainments are clarifying aspects of the history that provide a baseline against which changes in functional capacity may be compared. Velocity of progression and gradual versus sudden onset help differentiate the type of dementia present, as does age at onset. Sudden onset, irregular progression, or lateralization of neurological signs may point to multi-infarct dementia.

Painstaking history-taking will elicit information concerning practical functional capacity, such as the individual's ability to bathe, eat, cook, go to the toilet, perform household chores, and manage medication and money. It will further reveal whether the patient knows current assets, monthly expenses, physical and emotional ailments and proposed treatment. Seeing the patient with the family helps history-taking since the patient must often defer to them for explanations (5).

Toronto now has a multidisciplinary Competency Clinic staffed by a psychiatrist, a psychologist, an ethicist, and a lawyer. Each discipline contributes its own finding regarding competency and emphasis "has been to develop ways of assessing decision making per se, rather than making a inferential leap about decisions based on reductionistic tests (i.e. the Mini-Mental Status Examination)." Their Index of Competency serves as an interview guide and assessment addresses not only financial, health care and personal care choices, but also legal capacity such as the ability to instruct counsel or to be a witness at a trial (6).

Laboratory investigations

Appropriate investigations for a reversible type of dementia, as seen in 10 percent of cases, are essential and, in the authors' opinion, should be done routinely on an outpatient basis.

In many cases, investigations have been done by the primary care physician, but if not, the following tests need to be done routinely in all cases of dementia in which competency is in question: CBC, urinalysis, serology, EKG, T3, T4, TSH, B12, folic acid, electrolytes, and other tests as indicated depending on the clinical condition. Where clinically indicated, a CT scan of the head with and without contrast, an MRI of the head and an EEG may be done. PET and SPECT may be more promising in the long run, though currently these tests are only investigational and expensive. No confirmed biological marker tests are available for Alzheimer's disease, though research in that context is continuing.

Neuropsychological

The Folstein Mini-Mental Status is the most commonly used test to assess

cognitive functions, such as orientation to time and place, immediate recall, short-term memory, calculation, language and construction ability. Although questioned by some, in our opinion, it is an exceptionally useful screening test (7).

A 1990 study at Leiden University in the Netherlands found that when addressing the functions of orientation and memory, the Mini-Mental Status Examination (MMSE) yielded significantly better scores in persons without neurological or psychological disorders; those impaired in these areas did poorly. Limited formal education, impaired vision or hearing, and use of psychoactive drugs did not significantly affect scores (7). Molloy and colleagues standardized the MMSE by "setting explicit detailed guidelines for administration and scoring" and by allotting limited response time, and found that standardization decreased assessment time without affecting test reliability (8).

Only in the past 40 years has any systematic attempt been made to develop tests specifically normed for the elderly; the previous focus has been on child development and characteristics of young adults. The Wechsler Adult Intelligence Scale had no norms for people over age 65 until 1981 (9). Normative data remains inadequate because of oversight that "there are substantial normal aging decrements in several important cognitive domains" (4). Normal age-related changes, combined with the limited formal education frequently found in the elderly population, may create a picture of diminished intellectual capacity. Even now, when a 90-year-old person is administered the WAIS-Revised, scores are based on a population of persons 70 to 74 years old, thus understanding the person's abilities as a non-agenarian.

Clock Drawing Test

The Clock Drawing Test is an encouraging reminder that innovation of test procedures for the elderly is happening. Usually, tests to assess dementia have focused on "verbally medicated episodic and semantic memory dysfunction" (10). In early stages of Alzheimer's disease, however visuospatial skills may be the primary deficit in some patients (11).

In the Clock Drawing Test, the patient is provided with pencil and paper and instructed to draw a clock with all the numbers on it. Next, the patient is instructed to draw hands on the clock to make it read 2:45. Results of this test correlate highly with scores on the Global Deterioration Scale, the Blessed Dementia Rating Scale, and the Short Portable Mental Status Questionnaire in patients with dementia of the Alzheimer's type. This simple bedside test is a helpful adjunct to ascertaining dementia severity and can be done periodically on a longitudinal basis to assess the deterioration of functional capacity.

Becks Depression Inventory

We have observed that many individuals reporting symptoms of severe depression on the Beck Depression Inventory do poorly on the MMSE, but as the depression is effectively treated, the MMSE accuracy score increases upon retesting. False positive results are possible if an inadequate assessment is done.

Personality disturbances such as depression and schizophrenia must be taken into consideration in testing for organic brain impairment. Mental retardation also affects scores on the MMSE, particularly in moderate to severe retardation. A depressed or mentally retarded individual may develop dementia, and dual or even triple diagnoses are possible.

In early Alzheimer's disease, "depression and forgetfulness may be an early presenting symptom," with other symptoms such as confusion and disorientation not manifesting until later in the course of the disease (12). In fact, depression is probably the most common psychiatric disorder in old age, and late onset may be associated with genetic and developmental factors (15). Whatever the etiology, depression in the elderly should be treated aggressively, as it may mimic dementia in its clinical manifestations

Bender and WAIS-R

The WAIS-R, used alone, is of limited value in the elderly as it lacks norms for people over age 65. As LaRue points out, "the primary risk associated with neurological testing, as with many other procedures, is the overdiagnosis of dementia" (4).

In one study, the authors expressed concern over the lack of tests normed for the elderly, writing that "the feeling among those who work with older patients is that assessment tools designed for the general population are not necessarily useful in older subjects" (13). Reassessment at six-month or one-year intervals, preferably by the same psychiatrist/psychologist team, will provide a longitudinal view of impairment.

Emergency situations

In certain emergency situations, the consulting psychiatrist may agree with a surgeon that a particular surgical procedure is vital for a patient. However, applying the guidelines previously mentioned, the psychiatrist may not be able to determine whether the patient is competent to make the decision to undergo the procedure.

In the event that this happens, the family should always be consulted and consent obtained from them before the procedure is done. Criminal charges can be brought against the physician if proper consent has not been obtained; assault and battery are the legal terms for improper touching of a patient without proper informed consent.

Following the emergency situation, proper court proceedings to declare incompetence should occur. Competent geriatric patients who refuse medical or surgical treatment have been supported in their refusal by courts, even if such refusal has been found to be life-threatening (14). The ultimate issue is competency. If the patient is competent, his/her wishes are to be respected. If he/she is not competent, it is essential to proceed medically with the family's consent, which is in the patient's best interest while pursuing guardianship where feasible.

Conclusions

As the aging population swells, the need for geriatric competency assessment will grow. Psychiatrists and psychologists as a team will have a greater role in evaluation as the greying of the nation continues, and family physicians, who often assume care of those residing in nursing care facilities, will also become increasingly involved.

Psychopharmacological interventions and investigations have been disappointing. Drugs initially showing promise of enhancing memory in Alzheimer's patients have often failed to produce similar effects in larger controlled studies. Cholinergic drug studies involving choline, lecithin, tetrahydroaminoacridine (THC), physostigmine, and oxotremorine have yielded little hope; nor has memory enhancement occurred through use of serotonin uptake inhibitors.

Experimental use of neuropeptides (adrenocorticotropic hormone and arginine vasopressin growth hormone) has produced only limited results in

memory enhancement, but may produce more helpful results in patients with age-associated memory impairment. Ergot alkaloids improve mood and activity, but impact little on memory and learning. Continued clinical trials and research into drug interventions are necessary (e.g. higher doses of THC, nerve growth facilitating drugs), particularly in view of the tremendous toll of dementing disorders on the national economy and on the individuals suffering from dementia, as well as their caregivers.

Psychological tests normed specifically for the elderly are being developed, but more diagnostically definitive and task-encompassing tests are needed. More professionals are needed to assume responsibility for diagnostic assessment; there is now a scarcity of adequately trained professionals for the mental health care of older people, a population besieged by "missed diagnoses and misdiagnoses" (13). Psychological test results contribute by providing the physicians with longitudinal quantitive data to help determine whether a particular pharmacologic or non-pharmacologic intervention shows sufficient promise to warrant further study (4).

Until effective interventions for dementia are developed, competency will remain a burgeoning issue. Decisions as to competence have serious ramifications for the lives of people. Conclusions may deprive or empower an individual of the right to make or change a will, grant power of attorney, sit on a jury, stand trial, consent to treatment, manage money, live independently, or make health care decisions. Reliable competency assessment is thus more than a diagnostic tool; it is vital to the individual rights of the elderly.

References

1. Applebaum PS. Informed consent: legal theory in clinical practice. New York: Oxford University Press, 1987.
2. Sculc T. How can we help ourselves age with dignity? Parade Magazine 1988 May 29:4-7.
3. Green SK, Keith KJ, et al. Attitudes of medical students (letter to the editor). J Amer Geriatrics Soc 1983:31:713.
4. LaRue A. Neuropsychological testing. Psychiatric Annals 1984;14:201-6.
5. Poon LW, Seigler IC. Psychological aspects of normal aging. In: Sadavoy J, Lazarus LW, Jarvik LF, editors. Review of geriatric psychiatry: Washington D.C.: American Psychiatric Press, 1991:117-38.
6. Reichenfield HF. Determination of competence - the competency clinic at Baycrest Centre, Toronto. In: Lieff JD, Finkel SI, editors. AAGP Newsletter. Greenbelt, Maryland: Sandoz Pharmaceutical Corporation, Sep/Oct 1991:18-9.
7. Heeren TJ, Lagaay AM. Reference values for the mini-mental state examination (MMSE) Octo- and non-octogenarians. J Am Geriatrics Soc 1990;38:1093-6.
8. Malloy DW, Efrem A. Reliability of a standardized mini-mental state examination compared with the traditional mini-mental state examination. Am J Clin Psychiatry 1991; 148:102-5.
9. Granick S. Psychological assessment technology for geriatric practice. J Amer Geriatrics Soc 1983;31:728-9.
10. Sunderland T, Hill JL, Mellow AM, et al. Clock drawing in Alzheimer's disease. J Am Geriatric Soc 1989;37:725-9.
11. Hasan MK, Baker DG. Alzheimer's disease: recent advances. WV Med J 1987;83:427-9.
12. Kalayam B, Shamoian CA. Geriatric psychiatry; an update. J of Clin Psy 1990; 51:177-83.
13. Agbeyewa MO. An exploratory use of the symptoms checklist - 90 in a mixed geriatric study group. J Am Geriatrics Soc 1990;38: 773-6.
14. Law and psychiatry. In: Kaplan HI, Sadock BJ, editors. Comprehensive textbook of psychiatry. Baltimore: Wilkins and Wilkins, 1985:1481.

Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Hepatitis B surface antigen prevalence in blood samples tested at Cabell Huntington Hospital

YORAM ELITSUR, M.D.
XIA LIU, B.S.
Gastroenterology Division, Department of Pediatrics, Marshall University School of Medicine, Huntington

Abstract

Hepatitis B is a major cause of chronic liver disease which leads to morbidity and mortality among patients. In the current era, when federal and governmental support for health care is shrinking, the HBsAg+ carrier state in West Virginia becomes an important factor for future health care planning. In this study, we retrospectively investigated the HBsAg+ carrier rate in serum samples studied in the Cabell-Huntington Hospital Laboratory from January 1990 - January 1993. Only 50/6,209 (0.8%) serum samples were positive for HBsAg. These positive samples represented 10 different patients, 8/10 were females and only 4/8 were of child-bearing age. We conclude that HBsAg+ carrier state in patients from Cabell County is below the national average.

Introduction

Hepatitis B is one of the major causes of chronic liver disease which leads to cirrhosis and liver failure. Although almost 90% of adult patients with hepatitis B will recover, 5%-10% will develop chronic disease and may die from hepatocellular carcinoma or liver failure.

Epidemiological studies around the world have identified different endemic areas for hepatitis B infection. South Africa and countries in the Far East such as China, Korea, Indonesia, the Philippines and India, have a higher carrier rate, while the United States and Scandinavia have a lower carrier rate (1). Hepatitis B infection can be acquired through contaminated blood transfusion, sexual contact, human body fluids, and vertical transmission from a mother to her unborn child. Currently, hepatitis B vaccination is recommended by the American Academy of Pediatrics (AAP) for all newborns (2).

The incidence of hepatitis B in the population of West Virginia is unknown. Moreover, the hepatitis B carrier state among women of child-bearing age or among children is also unknown. The West Virginia Bureau of Public Health reported 87 cases in 1990, and 30 of these cases were women of child-bearing age and three were children under 14 years of age (3).

Since vertical transmission of hepatitis B is the major pathway to infect an unborn infant by his/her mother, it is critical to know how many pregnant women are carriers of this disease for future health care planning in West Virginia. The aim of our study was to investigate the hepatitis B carrier rate among the women who were utilizing OB/GYN services in Cabell County.

Materials and methods

Cabell County has one of the highest number of obstetrical deliveries among the counties in West Virginia, and serves as a major referral center for deliveries from residents in Kentucky and Ohio. The total number of OB/GYNs practicing in Cabell County, both academic and private sector, is 21 (4).

Since the HBsAg is routinely checked in the serum of all pregnant women treated in Cabell County and most of these blood samples are sent to the Cabell Huntington Hospital Laboratory, we retrospectively reviewed all blood samples sent for HBsAg detection during the period January 1990 - January 1993.

Results

A total of 6,259 samples were reviewed for our study. The male/female ratio was 1,281/4,877, and the gender was unspecified in 101 of the blood samples. Women were further divided into two categories -- those of child-bearing age (from 15 years to under 45 years of age) and those of non-child bearing age (under 15 years and over 45 years of age). Results showed that 82% of the women were in the child-bearing age group (CBA).

A total of only 50/6,259 (0.8 %) samples were positive for HBsAg. These positive samples represented only 10 different patients who were

TABLE 1. The incidence of positive serum HBsAg tested at Cabell-Huntington Hospital

YEAR	TOTAL	POSITIVE/NEGATIVE	MALES/FEMALES	GENDER UNKNOWN
1990	1,349	17/1,332	372/924	53
1991	2,714	24/2,690	619/2,071	24
1992	1,973	9/1,964	255/1,706	12
1993 (Jan.)	223	0/223	35/176	12
Total	6,259	50/6,209 (0.8%)	1,281/4,877	101

TABLE 2. The incidence of positive serum HBsAg among women's blood samples tested at Cabell-Huntington Hospital

YEAR	TOTAL	AGE (K/UNK) CBA	(POS)	NCBA	(POS)	
1990	924	818/106	641	2	177	2
1991	2,071	1,742/329	1,386	1	356	
1992	1,706	1,288/418	1,139	1	149	
1993	176	153/23	125		28	
Total	4,877	4,001/876	3,291	4	710	2
(%)			(82)	(0.01) (18)	(0.02)	

K/UNK - known/unknown age.
CBA - child-bearing age.
NCBA - non-child-bearing age.

repeatedly checked over a period of time. Eight of the 10 positive patients were female and four were in the CBA group (Tables 1 and 2). Overall, the incidence of HBsAg positive serum in women in the CBA was 4/3,291 (0.01%).

Discussion

The overall incidence of HBsAg in the blood samples was 0.02% (8/3,291). Our data concurs with the HBsAg+ carrier rate reported 20 years ago in the midwestern rural states (1). Nevertheless, more recent studies have reported a carrier rate at a national average of up to 30% (5).

Drug addicts and patients with hepatitis C and HIV are known to be at risk for hepatitis B (4,6). The lower rates of drug addicts and patients with hepatitis C and HIV in the West Virginia compared to the national average, may partially explain our low incidence of HBsAg-carrier patients.

Since only 20% of the blood samples were taken from males, a possible bias may exist for the estimation of the total HBsAg carrier rate among adults in Cabell County. More epidemiological research is warranted to further elaborate on our data.

Conclusion

In summary, we retrospectively reviewed the rate of HBsAg+ in the serum of all patients' blood samples sent through the Cabell-Huntington Hospital Laboratory. We found that the carrier rate for hepatitis B among women of child-bearing age, as well as the carrier rate for this disease among males, is lower than the national average.

References

1. Wewalka F. Epidemiology of hepatitis B antigen. In: Schaffner F, et al, editors. The liver and its diseases. New York: Intercontinental Medical Book Corporation, 1974.
2. American Academy of Pediatrics, Committee on Infectious Diseases. Universal hepatitis B immunization. American Academy of Pediatrics News 1992 Feb 13-15.
3. West Virginia Bureau of Public Health, Division of Surveillance and Disease Control. 1991 Jan.
4. Pulliam RP. Evaluation of the obstetrical care system in West Virginia. W Va Med J 1993; 89:6-14.
5. Frances DP, Prendergast TJ, Peterson E, Ginsberg MM, Lookabaugh C, Holms JR, et al. Occurrence of hepatitis A, B and non-A/non-B in the United States: CDC Sentinel County Hepatitis Study I. JAMA 1984;76:69-74.
6. Kelen GD, Green GB, Purcell RH, Chan DW, Qaqish BF, Siveston KT, et al. Hepatitis B and hepatitis C in emergency department patients. N Engl J Med 1992;326:1399-404.

Charleston Area Medical Center and The West Virginia University
Robert C. Byrd Health Sciences Center/Charleston Division
Present

3rd Annual Vascular Surgical Seminar
Lower Extremity Revascularization
Saturday, October 23, 1993

Featured Speakers:

John J. Bergan, M.D.
Past-President Society of Vascular Surgery
Clinical Professor of Surgery/University of California/San Diego
Robert A. Graor, M.D.
Professor of Vascular Medicine/Cleveland Clinic Foundation
Norman Hertzer, M.D.
President - Society of Vascular Surgery
Chairman - Dept of Vascular Surgery/Cleveland Clinic Foundation

Brian Thiel, M.D.
Secretary - Society of Vascular Surgery
Professor and Chief of Vascular Surgery
Penn State University/Hershey
Frank Veith, M.D.
Professor of Combined Dept. of Surgery
Albert Einstein College of Medicine

Program Director:
Ali F. AbuRahma, M.D.
Professor of Surgery/West Virginia University Robert C. Byrd Health Sciences Center/Charleston Division

Location:
Auditorium - West Virginia University Robert C. Byrd Health Sciences Center/Charleston Division

For additional information, please contact the CAMC - Continuing Education and Conference Services Department - 348-9581.

To Help You Get A Better Start, We Offer A 75% Savings Your First Year In Practice.

At CNA, we understand how tough it can be to get started in your medical practice. So, to help ease your burden, we're offering you a 75% premium reduction on your malpractice insurance during your first year in practice. In addition, you'll get a 50% premium reduction your second year and 25% the third year.

Even more important than these savings, you'll enjoy a relationship which can bring you peace of mind in the years ahead.

Doctors have been relying on the CNA Insurance Companies for malpractice protection for over 30 continuous years. A record which demonstrates our dedication to providing continual coverage even in uncertain times.

For more information, contact your local agent or:

McDonough Caperton Insurance Group
One Hillcrest Dr. East
P.O. Box 3186
Charleston, WV 25332-3186
(304) 346-0611

WVSMA
P.O. Box 4106
Charleston, WV 25364
(304) 925-0342

We're there when you need us most.

The WVSMA/CNA Physicians Protection Program is underwritten by Continental Casualty Company, one of the CNA Insurance Companies/CNA Plaza/Chicago, IL 60685. CNA is a registered service mark of the CNA Financial Corporation, the parent company of the CNA Insurance Companies.

CNA

For All the Commitments You Make®

President's Page

James L Comeri M.D.

Communication: A two-way street

Effective communication depends on a willing sender and a willing receiver of information, and we are all at one time either senders or receivers. The WVSMA's success as an organization depends upon effective communication between all branches of administration and the members. When we do not each take our responsibilities seriously in this process, communication often becomes one-sided and ineffective.

To keep communications constantly in motion, the WVSMA utilizes a variety of printed materials such as personal letters, the *Journal*, the *WESGRAM* and the *Legislative Update*. In addition, the WVSMA is structured to provide for a flow of information from leadership to members and from members to leadership in several ways. This organizational structure is shown in the diagram on this page.

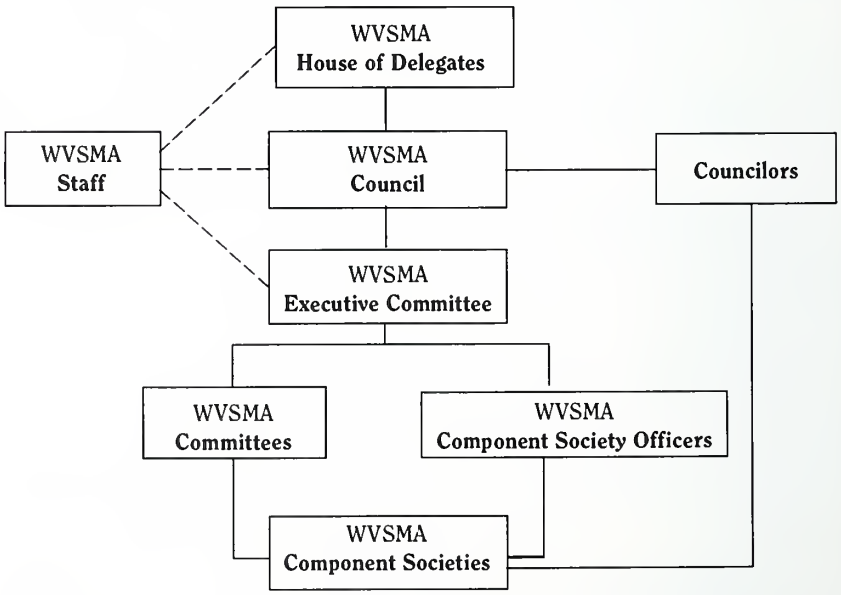
As you can see from this figure, information is meant to flow through different size groups as it travels either up or down the lines of communication. It moves from the Executive Committee to the membership through progressively larger groups and depends upon each section increasing the number of receivers along the way. As the information travels in the opposite direction, it goes through progressively smaller groups that rely upon someone to consolidate the information for presentation and possible decision-making.

While direct communication from the president to each individual member may seem more personal, it can often be more costly in time and money, and may actually be less effective. We, therefore, have to depend upon each level of the communication chain to see that either the preceding or following level receives the information, and that any responses to that information are transmitted in the other direction. If any of these levels break down, the process becomes ineffective. Success depends on the weakest link in the chain.

I feel the most important link in this chain is the Council. This body serves both as a decision-making body as well as a filter of information to the House of Delegates and the Executive Committee. Most importantly, it acts as a vital link to the component societies and their officers from the Executive Committee and the WVSMA administrative staff. The WVSMA as a whole can only be effective if the Council facilitates the flow of information in both directions. We need a strong and active Council, and we also need strong and active local officers who will utilize their councilors and provide information to their local members.

This year I plan to encourage our councilors to become more active in this communication process, and I have asked Winnie Martin to act as a liaison to the Council members for weekly communications throughout the year. To further encourage communication between members and their councilors, I have listed the names of all the councilors and their addresses, phone and fax numbers on

WVSMA Organizational Chart



this page. Unfortunately, as you can see, there are several component societies which do not currently have a member on Council. I hope these societies will act as soon as possible to place a member in this crucial role.

I need you as members to know your councilors personally. Ask them to attend all the WVSMA meetings and provide updates about the issues covered at your monthly meetings. I can only be effective if as many members as possible get involved in this process.

The WVSMA's future depends upon the strength of all the links in the communications chain. Please be a strong one!

James L. Comerci, M.D.

Current WVSMA Councilors

Boone
Ron D. Stollings, MD
705 Madison Avenue
Madison, WV 25130
369-5170 (O) 369-6194 (H) 369-1742 (F)

Brooke
Patsy P. Cipoletti Jr. MD (GP)
1421 Commerce Street
Wellsburg, WV 26070
737-3425 (O) 737-1964 (H)

Cabell
Phillip Stevens, MD (OFS)
#3 Stonecrest Drive
Huntington, WV 25704
522-6388 (O) 522-2508 (H) 522-8040 (F)

Jack Steel, MD (ORS)
2828 First Avenue #400
Huntington, WV 25701
525-6905 (O) 525-2407 (H) 525-9643 (F)

Central WV
Greenbrier Almond, MD (P)
48 South Kanawha Street
Buckhannon, WV 26201
623-3461 (O) 472-7372 (H) 623-7685 (F)

Eastern Panhandle
Edward Arnett, MD (PD)
2000 Professional Center
Martinsburg, WV 25401
263-8853 (O) 457-3169 (H) 264-1255 (F)
263-6178 (Private Line/CC)

Fayette
Samuel Davis, MD (DR)
PO Box 1107
Montgomery, WV 25136
442-5002 (O) 442-2821 (H)

Greenbrier Valley
Stephan Thilen, MD (ANES)
Greenbrier Anesthesia Services
PO Box 1104
Lewisburg, WV 24901-1104
645-6460 (O) 645-4000 (F)

Hancock
Antonio S. Licata, MD (GS)
3032 West Street
Weirton, WV 26062
797-9700 (O) 797-9701 (F)

Harrison
Thomas H. Chang, MD (GS)
4 Hospital Plaza
Clarksburg, WV 26301
623-3719 (O) 824-4214 (H) 623-3733 (F)

Kanawha
Glenn Crotty Jr., MD (END)
415 Morris Street, Suite 300
Charleston, WV 25301
344-8856 (O) 342-6306 (H) 345-6305 (F)

W. Alva Deardorff, MD (R)
PO Box 9219
South Charleston, WV 25309
766-7121 (O) 744-2661 (H) 768-0939 (F)

Sherman E. Hatfield, MD (OFS)
Doctor's Park
Columbia at Monongalia
Charleston, WV 25302
342-6806 (O) 768-9550 (H) 342-6819 (F)

Logan - (vacancy)

Marion
John A. Leon, MD (DR)
19 Pheasant Drive
Fairmont, WV 26554
366-2600 (O) 366-2080 (F)

Marshall
David Nally, MD (EM)
426 8th Street, Suite 305
Glen Dale, WV 26038
845-4340 (O)

Mason - (vacancy)

McDowell - (vacancy)

Mercer - (vacancy)

Monongalia
Richard Kerr, MD (OBG)
1192 Pineview Drive
Morgantown, WV 26505
598-0488 (O) 599-2651 (H) 598-3608 (F)

Paul F. Malone, MD (OTO)
1189 Pineview Drive
Morgantown, WV 26505
599-3959 (O) 599-7329 (F)

Steve Sebert, MD (FP)
149 Lamplighter Drive
Morgantown, WV 26505
293-5204 (O) 594-3522 (H) 293-5860 (F)

Jeffrey A. Stead, MD (PTH)
Monongalia General Hospital
Morgantown, WV 26505
598-1269 (O) 598-1261 (F)

Ohio
John Holloway, MD (I)
The Wheeling Clinic
58 16th Street
Wheeling, WV 26003
234-1999 (O) 233-3958 (H) 234-2169 (F)

Parkersburg Academy
Rutherford C. Sims, MD (OBG)
5 Rosmar Circle
Parkersburg, WV 26101
428-9000 (O) 422-4301 (H) 428-9010 (F)

Potomac Valley
Carl A. Liebig, MD (GS)
PO Box 206
Keyser, WV 26726
693-7616 (O) 788-0451 (H) 257-2537 (F)

Preston
Darryl L. Landis, MD (FP)
410 East Main Street
Kingwood, WV 26537
329-0780 (O) 329-2786 (H) 329-0789 (F)

Putnam - (vacancy)

Raleigh
Ahmed Faheem, MD (P)
1014 Johnstown Road
Beckley, WV 25801
252-4433 (O) 252-1703 (F)

South Branch Valley
Larry Rogers, MD (FP)
PO Box 7
Petersburg, WV 26847
257-4511 (O) 257-2537 (F)

Summers - (vacancy)

Tug Valley
Rao Vempaty, MD (GS)
50 West Third Avenue
PO Box 2038
Williamson, WV 25661
235-1953 (O) (606) 237-1187 (H)

Tygart's Valley
Fouad H. Abdalla, MD (R)
PO Box 1484
Elkins, WV 26241
636-3300 ext. 339 (O) 636-1925 (H)

Western - (vacancy)

Wetzel - (vacancy)

Wyoming
Shashikant B. Bhavsar, MD (FP)
Medical Center
PO Box 1630
Oceana, WV 24870
682-6246 (O) 732-6719 (H) 949-4525 (F)

Know the law regarding the new DNR Act!

Editor's Note: *This month we are pleased to publish an editorial which was submitted to us by Dr. Alvin Moss, the director of the Center for Health Ethics and Law at the Robert C. Byrd Health Sciences Center at WVU in Morgantown. DNR order cards may be obtained by contacting the Center for Health Ethics and Law at 1-800-WVA-MARS.*

A significant accomplishment of the West Virginia Legislature during the regular 1993 session was the passage of the Do Not Resuscitate Act (DNR Act). Prior to July 1, 1993, when emergency medical services personnel (EMS) were summoned to a patient in cardiac or respiratory arrest, their protocols required initiation of cardiopulmonary resuscitation (CPR) regardless of prior advance directives that may have declined CPR.

These EMS protocols were based on the law governing the Living Will and the Medical Power of Attorney which stipulates that two physicians, or one physician and one licensed psychologist, must personally examine a patient and find the patient lacking decision-making capacity before either of these advance directives becomes effective. Since physicians and psychologists do not usually accompany EMS personnel, the common practice had been for resuscitation to be started and for patients to be transported to an emergency room where determination of decision-making capacity and compliance with a patient's advance directive could be implemented.

The Legislature recognized that CPR rarely leads to prolonged survival in persons with chronic illnesses in whom death is expected and that many patients do not desire it. The intent of the DNR Act is to protect the right of patients to self-determination in decisions about CPR, to provide for out-of-hospital DNR orders, and to give direction to EMS personnel and others with regard to the performance of CPR in homes, ambulances, and communities throughout West Virginia.

According to this act, consent to CPR is presumed unless a DNR order has been issued; a patient has completed a Living Will and the Living Will is effective because the patient lacks decision-making capacity and is terminal or in a persistent vegetative state; or a patient has completed a Medical Power of Attorney that is effective and the patient's representative indicates the patient would not want CPR.

The act provides authority to issue DNR orders only to physicians. Physicians may issue DNR orders at the request of the patient, the patient's surrogate (if the patient lacks decision-making capacity), or with the concurrence of a second physician, if the patient is incapacitated and a surrogate decision maker is not available.

In the inpatient setting, the physician may issue a DNR order according to the policy of the hospital or the nursing home. In the outpatient setting, the attending physician may issue a DNR order according to the provisions of the DNR Act. The act specifies that when a physician gives a DNR order for an outpatient, the order is to be issued on a Do Not Resuscitate order card specifically described in the DNR Act. A copy of the card is shown here at the right.

The law provides immunity from criminal prosecution or civil liability for physicians and other health care providers who honor in good faith a patient's DNR order authorized in accordance with the provisions of the DNR Act. Furthermore, the law allows a physician to refuse to issue a DNR order as a matter of conscience and requires that this physician advise the patient or surrogate that he or she is unwilling to issue the order. In such circumstances, the physician shall permit the patient to obtain another physician.

The DNR law is now in effect and public education is taking place throughout the state. West Virginia physicians need to be knowledgeable of this law so that when their patients ask them about it they will be prepared to discuss it and possibly issue a DNR order. Moreover, many physicians may wish to recommend DNR orders to their patients who have chronic, progressive disorders or terminal illnesses for whom CPR would not be expected to be effective.

Alvin H. Moss, M.D.
Director, Center for Health Ethics and Law
Robert C. Byrd Health Sciences Center
West Virginia University
Morgantown

DO NOT RESUSCITATE ORDER

As treating physician of_____ and a licensed physician, I order that this person SHALL NOT BE RESUSCITATED in the event of cardiac or respiratory arrest. This order has been discussed with _____ or his/her representative _____ or his/her surrogate decision maker _____ who has given consent as evidenced by his/her signature below.

Physician Name_____
Physician Signature_____
Address_____
Person Signature_____
Address_____
Surrogate Decision Maker Signature
_____
Address_____

In My Opinion

Doctors and the Legislature

The West Virginia State Capitol is truly an elegant building. The gold-laden dome, the great marbled corridors, and the scenic grounds create a setting that would inspire anyone. On the surface, one would assume greatness, nobility, and an overwhelming desire to provide good laws for the citizenry of the wild, wonderful commonwealth known as West Virginia.

After experiencing firsthand the 71st West Virginia Legislature, though, I must say that my feelings are mixed and my conclusions vary on this point, but now at least I understand the process in more detail.

Despite all the criticism leveled at our elected leaders, one thing is clear, there are those delegates and senators who stand above the rest and deserve considerable respect for their efforts. Equally so, there are those who deserve unceasing criticism and no respect at all. Into this mix of personalities over 1,300 pieces of legislation were dumped this past session. It's a miracle the system works, yet work it does; albeit slowly and never to everyone's liking.

So what does all of this mean to doctors? It depends, of course, on who you ask. There are members of the medical profession who proclaim a sound disinterest in anything political. In some respects that's understandable. The life of a doctor is complex and stressful enough without adding in worries about state political activities. After all, as these docs profess -- "There's nothing anyone can do about the Legislature anyway." It's true the Legislature is not at the beck and call of the medical profession. Heaven forbid that ever be the case. We don't take care of our own House of Medicine well enough to dictate to the House of Delegates (or Senate) social or political policy.

We, as physicians, have a poor track record for securing desired legislation in this state. I suspect that in the short term there's likely to be no change. Elected representatives, whether doctors like it or not, respond to those who put them in office. West Virginia's physicians simply don't have the numbers on election day to outvote anyone and never will.

Since we can't deliver raw numbers, perhaps we could (and should) change our attitude and image. The general impression from the public is that doctors, in general, are cold-hearted, rich, unfeeling bastards. Lost in the public relations war is the fact that most physicians, particularly in this economically-depressed state, work harder and endure more cerebral stress than the public will ever understand. Sympathy for doctors just doesn't exist. It should not be society's prerogative to chastise an individual who attains success through hard work and sacrifice. Yet society does it anyway. Subsequently, most good physicians are caught in the crossfire.

Physicians have done a horrible job of public relations. Coming from the segment of society that deals with and is the expert on people, it makes our public relations failure even worse.

Can this situation be reversed? If so, are we doctors willing to pay the price and put our money where our mouth is?

In the coming months, the medical profession is about to be thrashed by government. Every aspect of what we do will be altered, observed, overseen, regulated, criticized, and manipulated. The medical profession is about to lose a major battle for its autonomy and self determination, but, it is conceivable that the future may see a medical profession with no choice but to become more cohesive and organized -- factors we've failed to achieve thus far.

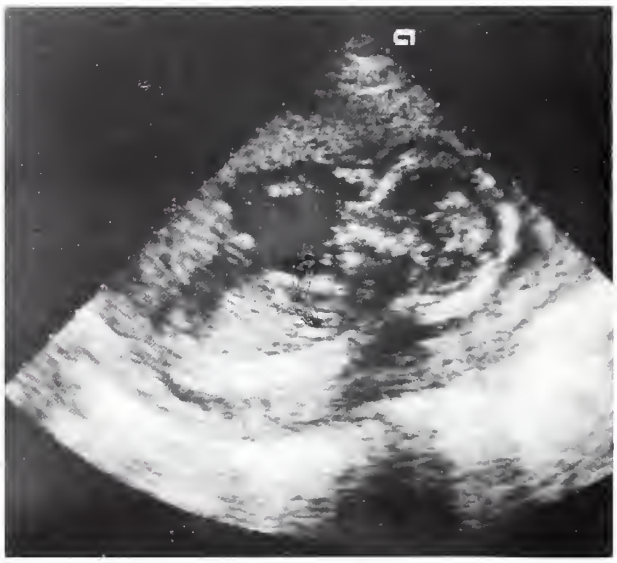
Could it be that government, in its attempts to control the practice of medicine, could actually make the medical profession more focused, determined, and a stronger political force? Wouldn't it be odd if government were to actually do us a favor?

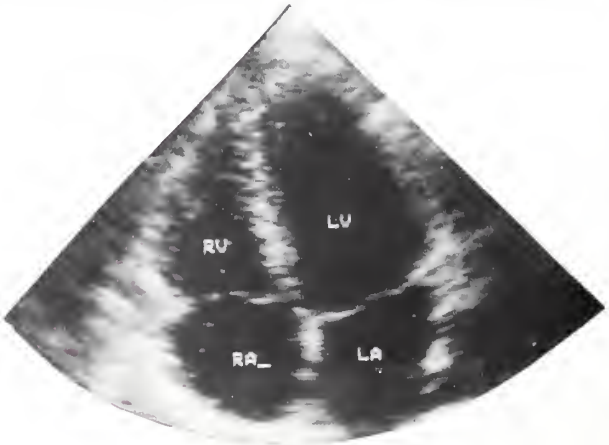
James D. Helsley, M.D.,
WVSMA Vice President
Morgantown

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time





Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

Laser Surgery Seminar X

SATURDAY, OCTOBER 30, 1993
CHARLESTON MARRIOTT

EYE • ENT • GYN • COSMETIC • CHEST • DERMATOLOGY • GENERAL SURGERY • UROLOGY • VASCULAR • ENDOSCOPY

A comprehensive update on the biophysics and uses of various lasers in surgery for physicians, nurses, nurse anesthetists and other health professionals

FACULTY

Francisco T Aledia, MD
Peter K Americo, MS, CCC-Sp
James P Boland, MD
Christopher J Daly, MD
Harakh V Dedhia, MD
Paul H Fulcher, Jr, MD
Richard C Haydon, MD
Haskins K Kashima, MD
Romeo Y Lim, MD
Bernard J Luby, MD
Robert E O'Connor, MD
Robert E Pollard, MD
Joseph T Skaggs, MD
George R Valentini, MD
R Austin Wallace, MD
Stafford G Warren, MD
Mary Jane Willis, PA
Moseley H Winkler, MD

SPECIAL GUEST OF HONOR

STEPHEN J WETMORE, MD

SPONSOR

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
The Laser Surgery Center

CO-SPONSOR

DEPARTMENT OF SURGERY, ROBERT C BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY
Charleston Division
CHARLESTON AREA MEDICAL CENTER

CREDIT

4.5 CME Units, 4.5 CE Units, AANA, .45 CEUs

FOR REGISTRATION INFORMATION, CONTACT:
ROMEO Y LIM, MD, SEMINAR DIRECTOR
MARY JANE WILLIS, PA, PROGRAM COORDINATOR
(304) 353-0227 or 1-800-642-3049 (WV)

7th FP Weekend/Sports Medicine Conference set

The West Virginia Chapter of the American Academy of Family Physicians will conduct their 7th Annual Family Practice Weekend and Sports Medicine Conference from November 12-14 at the Radisson Hotel in Huntington.

This event is sponsored by The Family Medicine Foundation of West Virginia; the Marshall University Department of Family and Community Health; the Marshall University Division of Sports Medicine; and the Marshall University Sports Science and Wellness Institute. It has been reviewed and is acceptable for 17.5 prescribed hours by the AAFP, and AAFP prescribed credit is accepted by the AMA as equivalent to the AMA's PRA Category 1. In addition, AOA credit toward Category 2-A for 17.5 hours is also approved.

Registration begins at 7 a.m. on Friday, November 12, and the first scientific presentation, "The Office Management of Shoulder Pain in the Young and Old Athlete," by Manny Molina, M.D., of Charleston, is planned for 8:20 a.m. Other lectures that morning include "Shoulder Rehabilitation" by Rabah Boukhemis, M.D., of Huntington; "Wrist Injuries," by Scott Riley, M.D., of Huntington; and "Diagnosis of Rear Foot Pain and Primary Treatment in Athletes" by Edwin Mow, D.P.M., of Huntington. All of these speakers will then be featured in a panel discussion.

Following lunch, the lectures will continue at 1 p.m. with a presentation entitled "Asthma/Allergies in the Athlete" by Bob Gibson, who played for the St. Louis Cardinals for 17 years and is a member of the Baseball Hall of Fame. After Gibson's talk, Douglas McKeag, M.D., of Michigan State University, will discuss "Ankle Injuries." The other afternoon lectures scheduled are "Sports Medicine: Exercise Prescription" by Jeffrey Tanji, M.D., of the University of California in Sacramento; "Benign Prostatic Hyperplasia: New Insights to Clinical Management Strategies - The Evolution of Treatment" by Stephen A. Kaplan, M.D., of Columbia Presbyterian Medical Center in New York City; and "Otitis Media with Effusion" by S. Kenneth Wolfe, M.D., of Huntington.

Saturday's schedule will start with registration at 7 a.m., and then the presentation, "Infection in the Elderly" by Martin Finklestein, Ph.D., of New York University in New York City, is set for 8:15 a.m. Other topics to be featured that morning will be "Vasodilators in the Treatment of Heart Failure" by Stuart D. Katz, M.D., of Columbia Presbyterian Medical Center; "The Difficult Diabetic" by Steven Leichter, M.D., of the Eastern Virginia Graduate School of Medicine; and "Endoscopic Sinus Surgery" by Stephen J. Wetmore, M.D., of WVU in Morgantown.

Gehr

Sherwood

Currie

After a break for lunch, the scientific sessions will reconvene at 1 p.m. with "Treatment of Depression" or "Porcelain Tighter Reduction" by Ronald D. Reynolds, M.D., of the New Richmond Family Practice Clinic in New Richmond, Ohio. Additional subjects to be highlighted that afternoon will be "A Clinician's Guide to the Management of Lipid Disorders," by Gary E. Ruoff, M.D., of the Michigan State University School of Medicine in Kalamazoo, Mich.; "Renal Issues in Hypertension" by Todd W. B. Gehr, M.D., of the Medical College of Virginia in Richmond, Va.; "Maintaining Partnership Between Industry and Medical Practice During an Era of Health Reform" by Louis M. Sherwood, M.D., of the Albert Einstein College of Medicine in New York City; and "The Value of Medicine" by Steven Skolsky, regional director of Cerenex Pharmaceuticals.

On Saturday evening, a meeting of the Family Practice Club is planned for 6:30 p.m. to discuss the topic of health care reform. At 7 p.m., a reception will take place at the Huntington Civic Center followed by a concert and dance from 8 p.m. to midnight featuring Charlie Brown and The Coasters and The Full Tilt Band. This concert/dance is a fund-raising event for the Family Medicine Foundation of West Virginia.

Sunday's programs will start at 8:15 a.m. with a talk by Paul Katz, M.D., of the Georgetown University Medical Center in Washington, D.C., on "The Use of Non-Steroidal Anti-Inflammatory Agents in the Elderly: Special Considerations." Also scheduled will be the sessions "Pain and Symptom Management of the Cancer Patient," by Neil M. Ellison, M.D., of Geisinger Medical Center in Danville, Pa.; "Modern Management of Human Papillomavirus Infections" by John L. Currie, M.D., of the Johns Hopkins University School of Medicine in Baltimore; "A Clinical Evaluation of Occupational and Environmental Problems: A Case Study Series" by Mohammed Ranavya, M.D., of Chapmanville; and "Dealing with Psychiatric Emergencies" by Jack Adams, M.D., of Huntington. The meeting will conclude at 12:30 p.m. after drawings for door prizes.

For more details, contact the WVAAFP at 776-1178.

Parkersburg Academy members provide 1,500 free sports physicals

Members of the Parkersburg Academy of Medicine recently finished conducting nearly 1,500 free sports physicals for junior and senior high school students in the Parkersburg area.

These exams were provided with the cooperation of local dentists, physical therapists and numerous other medical specialists. This is the third year that members of the Parkersburg Academy and these other area health care providers have donated their time to perform free physicals for students.

CAMC, WVU to sponsor trauma, vascular conferences in October

"Emerging Issues in the '90s" is the topic for the Eighth Annual Trauma Conference sponsored by the Charleston Area Medical Center and the Robert C. Byrd Health Sciences Center of West Virginia University which will take place in Charleston on October 8. In addition, CAMC and WVU are also conducting the Third Annual Vascular Surgery Seminar in Charleston on October 23.

Lectures for the trauma conference include "Field Management of Catastrophic Sports Injuries" by Dr. Randall Swain, an assistant professor at WVU, Charleston Division; "How the Legal System Can Help and Hurt Trauma Professionals" by Harry Teeter Jr., a lawyer and executive director of the EMS Council; and a discussion of the impact of managed competition on trauma lead by Dr. James W. Kessel, medical director of trauma services at CAMC.

A special highlight at this year's meeting will be a presentation on managing stress by Dr. James H. "Red" Duke Jr., one of the most-recognized medical television personalities. Dr. Duke is also a respected trauma surgeon and clinician, who established the Hermann Hospital Life Flight program in Houston, where he continues to work as medical director as well as director of trauma and emergency medical services. Dr. Duke's work to educate the public about health issues brought him into serious consideration for the post of surgeon general of the United States in 1989.

At the conference, Dr. Duke will relate his light-hearted prescription for managing stress and give advice on coping with any situation. He will share anecdotes and tapes as a counterpoint to his message.

The theme for the vascular surgery seminar is lower extremity re-vascularization and the keynote speaker will be Dr. John J. Bergan, past president of the Society for Vascular Surgery. Dr. Bergan will discuss "Surgical Alternatives for Aorta-Iliac Occlusive Disease."

Other featured speakers at the meeting will be Dr. Frank Veith, chief of vascular surgical services at the Albert Einstein College of Medicine, who will present "Distal Re-vascularization of Lower Limb Ischemia; Dr. Norman Hertzer, president of the Society for Vascular Surgery and chairman of vascular surgery at Cleveland Clinic Foundation, who will lecture on the subject of "Pre-operative Cardiac Evaluation Prior to Lower Extremity Re-vascularization;" and "Non-invasive Evaluation of Lower Extremity Arterial Occlusive Disease" will be discussed by Dr. Brian Thiel, professor and chief of vascular surgery at Penn State University in Hershey, Pa. The seminar will also offer lectures on the topics of management of pre-op complications, femoral PTFE techniques and non-conventional therapies.

To register for these meetings, contact the staff of CAMC's department of continuing education at (304) 348-9581.

Influenza vaccine to be distributed soon

The Bureau of Public Health's Immunization Program is preparing to launch its annual influenza vaccine program. According to the Volume 42, Number RR-6 MMWR, dated May 14, 1993, the optimal time for vaccinations for high-risk persons is between mid-October and mid-November. In the United States, influenza activity generally peaks between late December and early March.

Targeted high-risk populations include individuals 65 years of age and older; residents of nursing homes and other chronic-care facilities for residents of any age; adults and children with chronic pulmonary or cardiovascular disorders; adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases; and children and teenagers from 6 months old to 18 years who are receiving long-term aspirin therapy because they may be at risk of developing Reye syndrome after influenza.

This year, for the first time, Medicare will pay for flu shots. Reimbursable billing codes will be assigned to both the cost of the vaccine and an administration fee.

For more information regarding the influenza campaign, contact the Immunization Program at 1-800-642-3634 or (304) 558-2188.

New committee plans Philadelphia meeting

The Medical Action Committee for Education, which was established in June in an effort to maintain the quality of the U.S. health-care system by reducing the government's role in medicine, will host a regional meeting in Philadelphia at the Airport Radisson Hotel on November 6 and 7.

This meeting is designed to continue the MACE tradition of providing participants with an impressive slate of speakers, according to conference director Jerry Arnett, M.D., of Elkins, and co-director Nino M. Camardese, M.D., founder and president of the Ohio-based, national FREEDOM IN MEDICINE Foundation; a 501 (c) 3 Patient-Physician-Coalition-Educational Foundation. Speakers will include U.S. Rep. Dick Armey, R-Texas, who will discuss market-based ideas for health-care reform; Canadian physician William E. Goodman, M.D., of Toronto, who will talk about Canadian health insurance and civil liberties; and Kent Masterson Brown, legal counsel for the Association of American Physicians and Surgeons, who will talk about physicians' and patients' rights.

Other featured presenters will be internist Lois Copeland, M.D., of Hillsdale, N.J.; David Kelley, executive director of the Institute for Objectivist Studies in Poughkeepsie, N.Y.; Robert Moffit of the Heritage Foundation in Washington, D.C.; Dr. William Niskanen, chairman of the Cato Institute in Washington, D.C.; Brian McManus of the Golden Rule Insurance Co. in Indianapolis; Steven Reeder, M.D., of Physicians for Patient-Power in Dallas; and Greg Scanlon, executive director of the Council for Affordable Health Insurance in Alexandria, Va.

MACE has five major goals:

(1) To establish a grass-roots education program for patients and doctors;
(2) To defend and promote the private sector of medicine and research-based pharmaceutical companies;
(3) To fight against the establishment of price controls for physicians and prescription drugs;
(4) To keep medical care from being rationed in the U.S.; and
(5) To support market-based health-care reform that would include the establishment of medical savings accounts and medical IRAs.

Contact Dr. Arnett at (304) 636-8416 for more conference details.

The WVSMA / WVACP

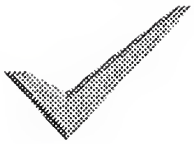
1994 Mid-Winter Seminars and Scientific Conferences

are just around the Corner

January 20-23, 1994

Lakeview Conference and Resort

Morgantown, West Virginia



Mark Your Calendar and watch for upcoming announcements.

The WVSMA's Mid-Winter Sessions will be held in conjunction with the Third Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians.

The Changing Environment of Medicine

Special topics to be featured include:

Joint Sessions

"Current Management of Cardiac Arrhythmias"
"Recent Advances in Gastroenterology"

Physician/Public Session

"Managed Care/Competition"

Controversies in Medicine

"Physician Assisted Suicide"
"Estrogen Replacement Therapy"

Environmental Medicine and Patient Communication

"Environmental Health Risk Communication - Why It's Important"
"Current Issues in Environmental Medicine"
"Epidemiologic and Occupational Studies - What Do They Tell Us?"
"What is ATSDR and Why Should You Care?"

Potpourri of Topics

"The Role of Carotid Endarterectomy"
"Norplant"
"Identifying Adolescent Alcoholics"

Successful Money Management Seminars

FOR WEST VIRGINIA STATE MEDICAL ASSOCIATION MEMBERS AND THEIR SPOUSES

- Huntington September 8, September 15 and September 22
- Beckley October 13, October 20 and October 27
- Parkersburg November 4, November 11 and November 18

Comprehensive Seminar Agenda

SESSION 1

- Your Foundation for Financial Independence
  - Why Everyone Needs Financial Planning
  - Six Main Objectives of Financial Planning
  - Reallocating Your Income
  - The Success Triangle™
  - Six Main Reasons People Fail Financially
  - Take Advantage of Your Lifetime Earning Power
  - Become Financially Independent;
  - The Eighth Wonder of the World—Compound Interest
  - The Effects of Inflation
  - Your Tax Bracket—How it Affects Your Financial Plan
- Putting Your Dollars to Work—Part I
  - Importance of Cash Reserves
  - Types of Cash Reserves
  - Restricted Cash Reserves
  - Tax-Deferred Fixed Annuities
  - Fixed-Income Securities
    - Government Securities
    - Corporate Bonds
    - Municipal Bonds
- Putting Your Dollars to Work—Part II
  - Equity Investments
    - Common Stock
    - Preferred Stock
    - Reading the Stock Tables
    - Risk Factors
    - Managed Accounts
  - Ten Steps to Financial Success
    - Your Personal Financial Plan—The Key to Your Success

SESSION 2

- Putting Your Dollars to Work—Part II
  - Mutual Funds
    - Families of Funds
    - Types of Funds
    - Dollar Cost Averaging
    - Selecting Specific Funds
    - Asset Allocation
  - Guaranteed Versus Equity Investments
  - Limited Partnerships
  - Tangible Assets
  - College Funding
- Retirement Planning
  - Social Security
- 401(k) Plans
- 403(b) Tax-Sheltered Annuities
- Simplified Employee Pensions (SEP-IRA)
- Individual Retirement Accounts (IRA)

SESSION 3

- Retirement Planning (continued)
  - Tax-Deferred Variable Annuities
  - Systematic Withdrawal Programs
  - Risk Management
  - Insuring Your Most Valuable Asset
  - Long-Term Health Care
  - Life Insurance
  - Enhancing Your Pension Benefits with Life Insurance
  - Estate Planning
    - Objectives of Estate Planning
    - Probate-Should it be avoided?
    - Living Revocable Trusts

SESSION 4

Optional

Everyone attending this seminar is entitled to a personal financial planning consultation after the conclusion of Session Three. This is your opportunity to ask specific personal questions regarding your financial future at no additional cost.

ENROLLMENT FORM

(Member's Name) _____ (Spouse's Name) _____

(Mailing Address) _____

(Telephone Number) _____ (Seminar Location I Plan To Attend) _____

Call (304) 925-0342 for more information.

Registration Fee: $250 (member) $125 (spouse)

Bonus for early registration: If registration is confirmed 10 days prior to the seminar, the spousal fee will be waived.

* Make check payable to West Virginia State Medical Association
* Mail enrollment form and fees to: West Virginia State Medical Association
  P. O. Box 4106
  Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

CAMC/Robert C. Byrd Health Sciences Center of WVU - Charleston

Oct. 7 - "Teleconference on the Medical Device Tracking Act," noon - 1 p.m., Robert C. Byrd HSC of WVU, Charleston

Oct. 8 - "Eighth Annual Trauma Conference," 8 a.m. - 5 p.m., Charleston Marriott Hotel

Oct. 21 - "Teleconference on Diabetic Retinopathy - Assessment and Intervention Strategies," noon - 1 p.m., Robert C. Byrd HSC of WVU, Charleston

Oct. 23 - "Third Annual Vascular Surgery Seminar - Lower Extremity Revascularization," 8 a.m. - 12:15 p.m., Robert C. Byrd HSC of WVU, Charleston

Oct. 27 - "Ethical Dilemmas in Pain Management," 8 a.m. - 12:45 p.m., Robert C. Byrd HSC of WVU, Charleston

Raleigh County Medical Society - Beckley

Sept. 21 - "Ace Inhibitors and Heart Failure," Michael B. Higginbotham, M.D., Black Knight Country Club, 6:30 p.m.

Sept. 28 - "Dealing with Insomnia in Clinical Practice," Ahmed D. Faheem, M.D., Black Knight Country Club, 6:30 p.m.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

Sept. 24-25 -"Surgery Update 1993" (sponsored by the WVU Dept. of Surgery and the West Virginia Chapter of the American College of Surgeons), Robert C. Byrd HSC of WVU, Morgantown*

Sept. 30 - Oct. 2 - "19th Annual Hal Wanger Family Medicine Conference" (sponsored by the WVU Dept. of Family Medicine and the West Virginia Chapter of the American Academy of Family Physicians), Robert C. Byrd HSC of WVU, Morgantown*

Oct. 8 - "New Developments in the Treatment of Panic Disorders" (sponsored by WVU Dept. of Behavioral Medicine and Psychiatry), Robert C. Byrd HSC of WVU, Morgantown

Oct. 9 - "1993 Appalachian Regional Stroke Symposium," (sponsored by the WVU Dept. of Neurology), Mountainview Regional Rehabilitation Hospital, Morgantown*

Oct. 15-16 - "Fourteenth Annual Clinical Ophthalmology Conference" (sponsored by the WVU Dept. of Ophthalmology), Lakeview Resort and Conference Center, Morgantown

Oct. 15-16 - "Pediatric Oktoberfest '93" (sponsored by the WVU Dept. of Pediatrics), Robert C. Byrd HSC of WVU, Morgantown

Oct. 22-23 - "3rd Annual N. Leroy Lapp, M.D. Internal Medicine Teaching Days" (sponsored by the WVU Dept. of Medicine), Robert C. Byrd HSC of WVU, Morgantown

Oct. 22-23 - "Orthopedic Reunion Day," (sponsored by the WVU Dept. of Orthopedics), Mountainview Rehabilitation Hospital, Morgantown*

**Held in conjunction with a home football game*

West Virginia State Medical Association - Charleston

Nov. 13 - "Marbury v. Madison Loss Control Program," Charleston

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Fairmont ★ Fairmont Clinic, Oct. 20, 1 p.m., "Screening and Preventions," Roxann Powers, M.D.

★ Fairmont General Hospital, Oct. 5, 7:30 p.m., "Coronary By-Pass Surgery - Current Status," Ronald Hill, M.D.

Man ☐ Man Appalachian Regional Hospital, Sept. 21, 7 p.m., "Abdominal Trauma," Bruce Hoak, M.D.

New Martinsville ★ Wetzel County Hospital, Oct. 14, 11:30 a.m., "Workers' Compensation: The WV Statute, Physician Obligations and Common Procedures," TBA*

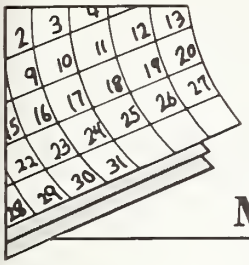
Point Pleasant ☐ Pleasant Valley Hospital, Sept. 23, noon, "Developing a Competitive Practice," Sharon King and Bill Davis

South Williamson ☐ South Williamson Appalachian Hospital, Sept. 23, 5:30 p.m., "Risks and Indications for Blood Transfusions," Mary B. Taylor, M.D.

Spencer ☐ Roane General Hospital, Sept. 21, 12:30 p.m., "Management and Treatment of Acute Myocardial Infarction," Harold Selinger, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Sept. 27, 4 p.m., "Rheumatoid Arthritis - Diagnosis and Treatment," Jo Ann Allen, M.D.

**To be announced*



Medical Meetings

October

1–Recertification: New Evaluation Methods and Implementation Strategies (sponsored by the American Board of Medical Specialties Research and Education Foundation), Chicago

1-3–International Liver Symposium (sponsored by George Washington University Medical Center), Arlington, Va.

9-13–Medical Oncology Board Review Course (sponsored by George Washington University Medical Center), Pentagon City, Va.

9-13–Gastroenterology Board Review Course (sponsored by George Washington University Medical Center), Arlington, Va.

10-15–4th International Conference on Non-Invasive Cardiology, Limassol, Cyprus

13-17–37th Annual Meeting of the American Society of Internal Medicine, Washington, D.C.

16-18–Linking Community Development and Rural Health (sponsored by the WV Bureau of Public Health), Beckley

21-23–New Techniques and Concepts in Cardiology (sponsored by the American College of Cardiology), Washington, D.C.

24-29–Interasma 93 - XIV World Congress of Asthmology (sponsored by International Association of Asthmology), Jerusalem, Israel

24-27–15th Annual Society for Medical Decision Making Meeting (sponsored by George Washington University Medical Center), Raleigh/Durham, N.C.

25-29–1993 State-of-the-Art Conference of the American College of Occupational and Environmental Medicine, Dallas

28-31–87th Annual Scientific Assembly of the Southern Medical Association, New Orleans

28-31–Intense Orthopedic and Sports Medicine MRI Weekend Review (sponsored by MRI Education Foundation, Inc.), Cincinnati

November

3–Fourth Annual Rush Symposium on Transplantation, Rush-Presbyterian-St. Luke's Medical Center, Chicago

4-7–12th Annual Scientific Meeting of the American Pain Society, Orlando, Fla.

6-7–Dermatology for the Non-Dermatologist (sponsored by Ohio State University), Columbus

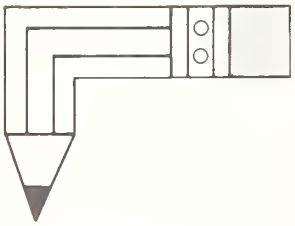
7-12–3rd International Conference on Pediatric Otorhinolaryngology of the European Working Group on Pediatric Otorhinolaryngology, Jerusalem, Israel

8-11–The Future of Integrated Healthcare Systems (sponsored by The Healthcare Forum and Inova Health System), Reston, Va.

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner

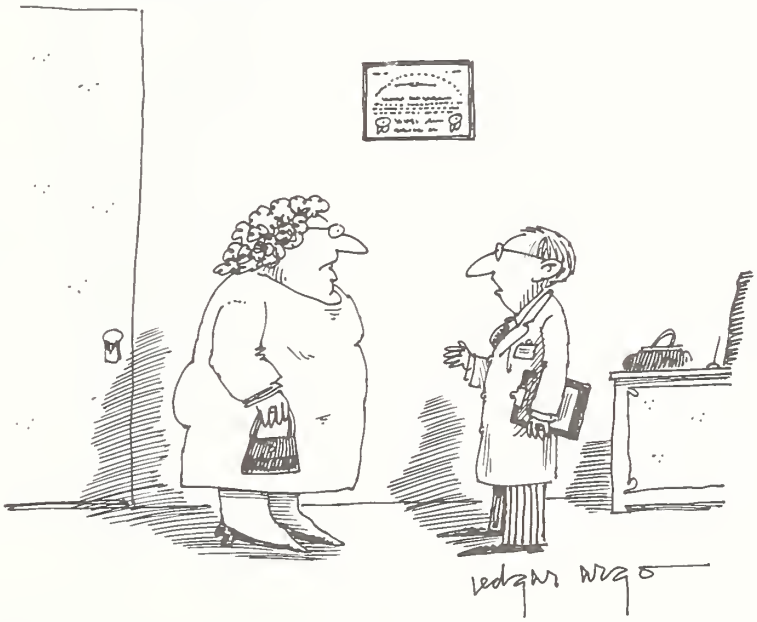


Hospital Delusions

I, a mere speck on the ceiling,
gaze down white mountains
through swirls of pain
as meaningless voices echo
across cloudy valleys.
On the t.v., my son-in-law
converses with celebrities,
although I know that Lesley
cannot be Morley.
By my bedside sits
a devilish smile and dancing eyes,
and I wonder if I'm in hell
and the devil looks like Keith
or if I still exist
and Keith is here.

Wilma Stanley Acree
Vienna, WV

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.



"YOU'RE RETAINING ICE CREAM!"

The WVSMA & Conomikes Associates, Inc.

Present

MANAGED CARE

How to deal with it properly

- How to avoid HMO/PPO contracting traps
- Capitation vs. Fee-for-Service
- How to get paid what you deserve

Charleston - September 28 Charleston Area Medical Center
3110 MacCorkle Avenue
9 a.m. to 4 p.m. (Lunch provided)

Registration Form

MANAGED CARE: How to deal with it Profitably

Enrollee Name _____

Physician's Name _____

Address _____

City _____

State _____ Zip _____ Phone _____

WVSMA member ($195) ____ Non-member ($225) ____
2 or more ($175) ____ 2 or more ($200) ____

Payment by: Check ___ Visa ___ Mastercard ___

Card Number _____

Expiration Date _____

Signature _____

Registration Fees:

$195 per person (Members/Member's Office staff)
Two or more persons from the same practice $195 for the first enrollee and $175 for each additional enrollee

$225 per person (Nonmembers/Office Staff)
Two or more persons from the same practice $225 for the first enrollee and $200 for each additional enrollee

NOTE: To register more than one person, copy and complete information on a separate sheet.

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

LUMP BETWEEN LOWER LIP AND GUM.

BAD BREATH.

STAINED FINGERS.

TOBACCO-STAINED TEETH.

WHITE PATCHES AND SORES.
Leukoplakia. In time, could lead to oral cancer.

RECEDING GUMS.

TOBACCO JUICE.

TWITCHY, WIRED LOOK CAUSED BY NICOTINE.
A high nicotine content makes smokeless tobacco just as addicting as cigarettes.

STUBBORN ATTITUDE. WON'T LISTEN TO SOUND MEDICAL ADVICE.

DRIBBLE CUP.

TIN BULGES AND RING.

NO FRIENDS.

HOW TO SPOT A DIP.

DIPPING IS FOR DIPS.
DON'T USE SNUFF OR CHEWING TOBACCO.

AMERICAN CANCER SOCIETY®

This page of material is submitted and paid for by the Bureau of Public Health.

Required reporting plays important role in disease control

West Virginia Code, Chapter 16-2-1, and Reportable Diseases Legislative Rules, Series 7, 1991, are two items with which physicians and other health care providers practicing in West Virginia need to be very familiar. They relate to the legal requirements of medical providers in regards to reporting to the appropriate agency, certain diseases and conditions. These reports are essential for effective statewide disease surveillance.

The object of disease surveillance is to determine the extent of disease occurrence and the risk of disease spread, so that control measures can be applied effectively and efficiently. This entire process begins with the physician complying with state law and legislative rule to submit the required disease report, in a timely and complete manner. It should also be understood that there are legal penalties for failure to comply with the law.

The information contained in the physician's report is invaluable in the control and prevention of disease. It is not only important to communities and the state, but reports are also forwarded to the Centers for Disease Control and Prevention where they are integrated into the national surveillance system.

In this age of computerization, access to timely information can also aid the practicing physician in the diagnosis of acute conditions, and can, in some situations, avoid the ordering of extra, unnecessary tests. The better the reporting among physicians in a community, the better the information practicing physicians can get when they call to inquire about a recent "cluster" of cases.

The three categories of diseases reportable by physicians and hospitals are as follows:

Category I - To be reported within 24 hours by telephone to the county health department, including case name, address, age and sex:

*Botulism
*Cholera
*Diphtheria
*Foodborne Diseases
*Gonococcal Disease:
- Pelvic Inflammatory Disease
- Drug-resistant
- Conjunctivitis in the newborn
*Meningitis, septicemia or other invasive disease due to Neisseria meningitidis or Hemophilus influenzae
*Plague
*Poliomyelitis
*Syphilis - primary, secondary, early latent (less than one year) and congenital
*Waterborne Disease
*Yellow Fever

Category II - To be reported weekly by name, address, age and sex to the county health department:

*Amebiasis
*Anthrax
*Brucellosis
*Campylobacteriosis
*Chancroid
*Chlamydia trachomatis
*Conjunctivitis in the newborn, other than gonococcal
*Encephalitis
- Post-infectious
- Primary and unspecified
*Giardiasis
*Gonorrhea (except those in Category I)
*Hepatitis
- Type A
- Type B
- Non-A, Non-B
- Type C (Non-A, Non-B)
- Type D
*Herpes Simplex Virus, Type 2
*Leptospirosis
*Lyme Disease
*Malaria
*Meningitis, Other Bacterial
*Meningitis, Viral or Aseptic
*Mumps
*Pertussis
*Psittacosis
*Rabies in animals or humans
*Rheumatic Fever
*Rickettsial Diseases
- Typhus Group:
- Endemic Typhus (louse borne)
- Murine Typhus (endemic - flea borne)
*Rubella
*Rubella, Congenital Syndrome
*Rubeola
*Salmonellosis (except Typhoid Fever)
*Shigellosis
*Syphilis (late latent)
*Tetanus
*Trichinosis
*Tuberculosis (All forms)
*Tularemia
*Typhoid Fever

Category III - Reported weekly by numerical totals to the county health department:

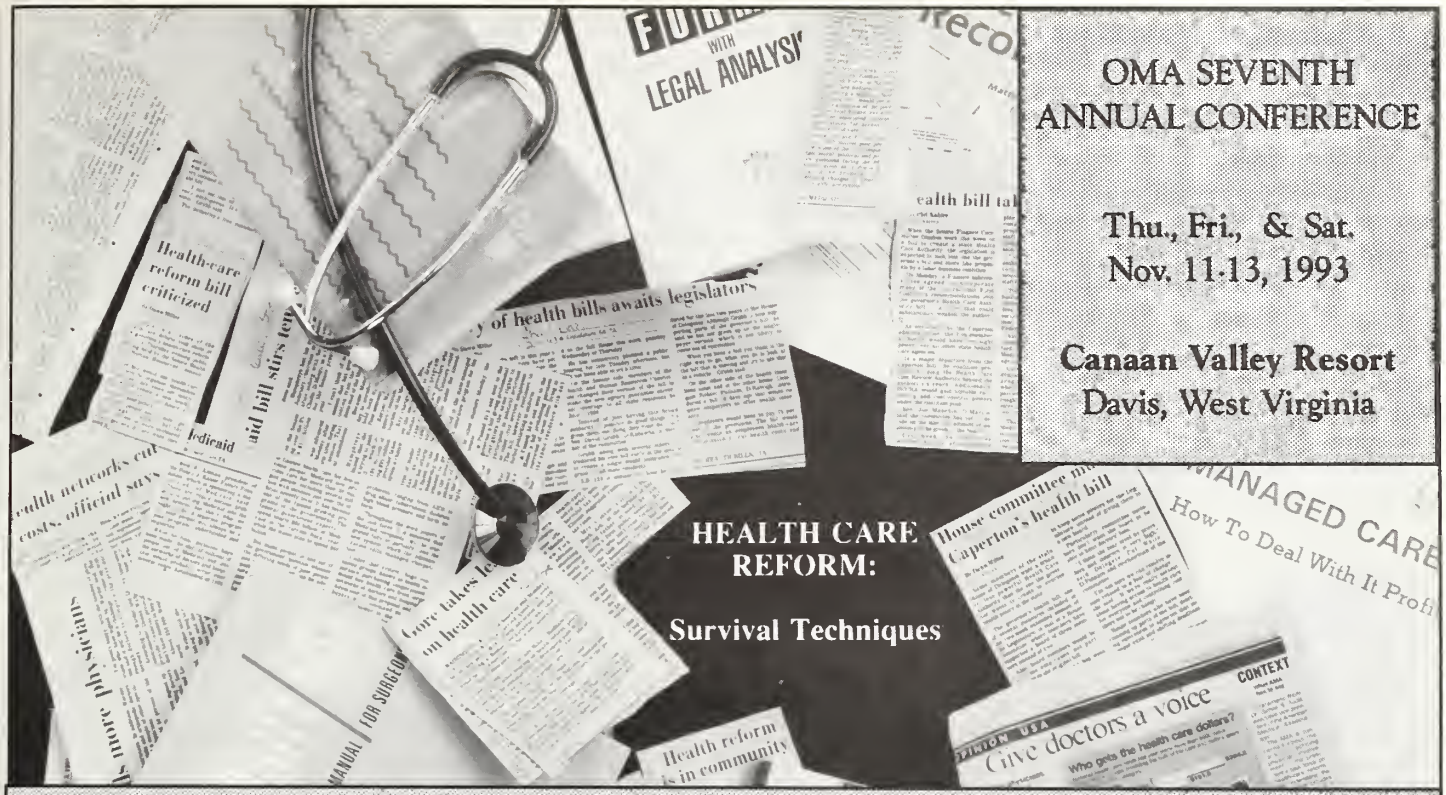
*Chickenpox
*Influenza-like illness

Category IV - Illnesses of unusual prevalence or clusters of unexplained health occurrences to be reported by name, age, sex and specified disease information to the State Bureau of Public Health, according to protocols specified by the Health Commissioner:

*Symptomatic infection with the Human Immunodeficiency Virus (HIV), including persons with AIDS and with other illnesses falling in Groups I, III and IV of the CDC HIV infection classification
*Birth Defects
*Cancer
*Dengue
*Hemophilia
*Lead Poisoning
*Occupational-related illnesses
*Unusual or ill-defined conditions

Report forms are provided by the Bureau and distributed by county health departments. Call your county health department for questions about which report forms to use, what information is required to be reported, or what possible diseases may be prevalent in your community.

For epidemiologic consultation, surveillance and disease investigation, phone the Bureau at 1-800-423-1271.



Where quality is affordable . . .

Participating Dealer For AMERINET, SUNHEALTH, and VHA ACCESS

BEAUTIFUL OFFICE SUITES in easy to visualize arrangements featuring styles in TRADITIONAL, CONTEMPORARY, PERIOD and more. Enjoy the beauty of CHERRY, OAK, MAHOGANY and WALNUT. You'll find them all on our showroom floors.

CUSTOM OFFICE FURNITURE, INC.

1260 GREENBRIER ST. CHARLESTON, WV 25311

INTERIOR DESIGN SERVICE
SPACE PLANNING

PHONE 343-0103 or 1-800-734-2045
WV CONTRACTOR NO. WV008652

ROBERT C. BYRD HEALTH SCIENCES CENTER

OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown.

Three new members named to WVUH Board of Directors

Mullett

James Jeffrey of Logan, Robert Wharton of Buckhannon, and Dr. Martha Mullett, WVU Hospitals' new chief of staff, have been named members of the WVUH Board of Directors.

Jeffrey has served as president of Southern Equipment Company for 20 years. Wharton is president and owner of R.L. Wharton, Ltd. and vice president and owner of Ross and Wharton Gas Co. Mullett is the director of the Neonatal Intensive Care Unit at WVUH. She received her medical degree at WVU, where she also completed a residency.

The board, which has members from across the state, sets policy for the non-profit corporation which operates Ruby Memorial Hospital, WVU Children's Hospital and the Jon Michael Moore Trauma Center.

Charlton appointed to national committee

Charlton

Dr. Judie Charlton, assistant professor of ophthalmology, was recently appointed to the American Academy of Ophthalmology's Residency Review Committee.

The committee visits and reviews all ophthalmology residency training programs in the United States and awards credentials to the programs that meet the designated criteria. Dr. Charlton will serve as a member of the committee for the next six years.

Dr. Charlton is medical director of the University Eye Center and director of WVU's ophthalmology residency training program.

Surgery announces faculty status changes

The Department of Surgery recently announced these promotions, tenures and certifications:

- Dr. Richard Vaughan was promoted from assistant professor to associate professor, and Dr. Alex Vasilakis was promoted from instructor to assistant professor.
- Dr. Julio Hochberg, associate professor; Dr. John Prescott, associate professor; and Dr. William Ramsey, associate professor; received tenure for 1993.
- Dr. David Jones, research associate; Dr. Mark Nelson, research associate; and Dr. Vasilakis were certified by the American Board of Surgery. In addition, Dr. Kenneth Granke, assistant professor, has added vascular surgery qualifications to his ABS certification.

CREM announces surveillance project

The Injury Control and Demonstration Training Center (ICTDC), which is operated by WVU's Center for Rural Emergency Medicine (CREM), is nearing completion of an injury surveillance mechanism to be implemented at Ruby Memorial Hospital.

"The surveillance mechanism will allow us to accurately determine the nature and incidence of injuries," says Dr. Janet M. Williams, research director. "Using the surveillance data, the ICTDC will develop and distribute intervention and prevention strategies targeting the injuries specific to the region. The ICTDC plans to extend the surveillance project to other interested emergency departments in West Virginia," she added.

Ramadan, Ghalichebaf attend XV world conference in Turkey

Dr. Hassan Ramadan, assistant professor of otolaryngology, and Mohssen Ghalichebaf, DDS, associate professor of prosthodontics, participated in the XV World Conference of Otorhinolaryngology from June 20-25 in Istanbul, Turkey.

At the conference, Dr. Ramadan discussed "Endoscopic Treatments of Middle Turbinate Headaches," and Dr. Ghalichebaf presented "The Role of Maxillofacial Prosthodontics in Rehabilitation of Acquired Extra-Oral Defects."

Health professionals from 52 countries attended the conference.

Cardiologists treating coronary artery disease with new device

Physicians in the Department of Medicine, Section of Cardiology, recently began using a new device called the Transluminal Extraction Catheter system (TEC) to treat coronary artery disease.

TEC is a microsurgical cutting device that shaves the plaque that causes a blocked artery while a vacuum feature extracts the excised debris.

Dentino presents research paper

Dr. Andrew Dentino, chief resident of behavioral medicine and psychiatry, presented a research paper during the Southern Association for Geriatric Medicine's (SAGM) third annual meeting, June 25-27, in Naples, Fla.

Dr. Dentino presented "Elder Abuse: The Screams Within the Silence" which provided timely information regarding the care of geriatric patients. His research paper was one of six papers selected for presentation at the meeting, which was sponsored by the Southern Medical Association in conjunction with SAGM.

WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF CONTINUING MEDICAL EDUCATION

Third Annual N. LeRoy Lapp, MD Internal Medicine Teaching Days

October 21 - 23, 1993

Health Sciences Addition Auditorium
Robert C. Byrd Health Sciences Center
Morgantown, West Virginia

Registration Form

Registration is recommended by October 8, 1993

Name _____ Degree _____
(MD, PhD, etc.)

Address _____

City _____ State _____ Zip _____ County _____

Daytime Telephone ( ) _____ Home Telephone ( ) _____

Social Security Number _____ - _____ - _____ Affiliation _____

Specialty _____ Subspecialty _____

Please specify the exact name to be printed on your certificate. Print or type name.

_____

Course Fees*

	Price	Total
Thursday (one hour only), Friday and Saturday	**$150.00**	$
Football Tickets (limit 4) WVU vs. Pitt	$20x ____	$
# of guests attending "Mountaineer Physicians" Pre-game Tent	# _____	no charge
**Course fees include conference materials, meals, and Saturday parking.*	**Total**	$

Credit Card payment: Please charge my ☐Visa ☐MasterCard Card number _____

Expiration Date _____ Authorization Signature _____

Make check payable to ***WVU Foundation*** and return with this form to:

Office of Continuing Medical Education
1250 Health Sciences South
PO Box 9080
Morgantown, WV 26506-9080 Fax #(304) 293-4891

Special Requirements

If you require access and parking for the handicapped, please describe:

_____

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

Drs. Moat, Tolley, Brosius recognized by MUSOM alumni

School of Medicine alumni and friends honored Dr. Albert Moat, the late Dr. Gary Tolley and the late Dr. David Brosius during the school's seventh annual alumni weekend earlier this month.

Alumni awarded honorary memberships in the MUSOM Alumni Association to Dr. Tolley and Dr. Moat. For more than a quarter of a century, the late Dr. Tolley served the Huntington community through the practice of diagnostic radiology, therapeutic radiology and nuclear medicine as a member of Radiology, Inc. A long-standing member of Marshall's clinical faculty, Dr. Tolley became professor and chairman of the Department of Radiology in 1989, a post he held until his death in January.

Dr. Tolley served as chief of radiology at Cabell Huntington Hospital for six years. He was a past president of the Cabell County Medical Society and the Cabell Huntington Hospital medical staff. As a practitioner and leader, Dr. Tolley made a major contribution to the evolving excellence in health care observed in our region. In addition to his honorary membership in the MUSOM Alumni Association, a memorial scholarship has been established in Dr. Tolley's name at the School of Medicine.

Dr. Moat joined the faculty of the School of Medicine in 1978, following a 25-year career at Hahnemann Medical College in Philadelphia. At Marshall, he served as professor and chairman of the Department of Microbiology until 1991, then continued in that position on a temporary basis through 1993.

He has written a number of scientific papers, literature reviews and textbook chapters on pyridine nucleotide biosynthesis and turnover, amino acid biosynthesis and transport, purine biosynthesis and turnover, and other publications on nutrition, metabolism and genetics of microorganisms. The first edition of his textbook *Microbial Physiology* was published in 1979. The second edition, co-authored with Dr. John W. Foster, was published in 1988.

In addition, the first David A. Brosius, M.D., Memorial Scholarship was presented to Christopher DeWese of Ikes Fork, W.Va. This scholarship was created to honor Dr. Brosius, a 1983 graduate who was dedicated to his Braxton County patients. The scholarship will be presented each year to a promising freshman medical student who shows a commitment to practicing in West Virginia.

Applications rise again; majority of students from rural areas

Applications to the School of Medicine rose sharply again this year according to Cynthia Warren, director of admissions.

The greatest increase came from in-state residents, Warren said. This year, 215 West Virginia residents applied, an increase of 19 percent over last year's total of 180, and a 56 percent increase over the 1991-92 total of 138. Marshall has 1,415 applications in all, 17 percent more than last year and 36 percent more than in 1991-92.

According to Warren, the quality of applicants remains high. In fact, she said there were enough qualified applicants left on the reserve list to more than fill another class of 48.

Twenty-one West Virginia counties are represented in the entering class. Two-thirds of the in-state students in this class are from rural areas, and one-third are first-generation college students; only 8 percent come from physician households.

The 1993 entering class has the highest-ever percentage of women with 43 percent. The mean age of class members is 26.7 years and three students are more than 40 years old; a dozen more are at least 30.

In addition to traditional students (among them a Yeager Scholar), the entering class includes a retired Army officer, a former Peace Corps volunteer and several medical technologists. Eight students already have master's degrees.

Dr. Patrick I. Brown, associate dean for academic and student affairs, said that increased awareness of innovative rural health programs at Marshall seems to be a factor.

Faculty present achievement awards to top students

A dozen medical students received awards in the school's 1993 Opening Exercises August 25, in honor of their achievements during the 1992-93 academic year.

Year I Achievement Awards went to Edward Scott Brumfield of Wayne and Christopher Skaggs of Ansted, who tied for the top award, and to Kent V. Lucas of St. Mary's, who received the second-highest ranking.

Four students tied for the Year II Achievement Awards with perfect 4.0 grade averages: Ramona Davidson of Williamson, Kevin S. McCann of Chapmanville, Mark R. Ziegler of Huntington and Erich R. Heinz of Proctorville, Ohio.

Five third-year students received awards for their 4.0 averages last year; three were traditional students and two spent most of their academic year working alongside rural physicians through Marshall's Rural Physician Associate Program. The top students were Caroline E. Miller and Tammy L. Nagy of Hurricane, and Patricia L. Wilson, Betts Carpenter and Bradley Richardson of Huntington.

The Laser Surgery Center

- 35-bed JCAHO Accredited Hospital
- Ambulatory Care/ Same Day Surgery

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH

EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD
Robert E. Pollard, MD

Specializing in
Head and Neck Cancer Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)
FAX (304) 353-0215

Ed's MED
Medical Waste Systems

We specialize in the legal transportation and disposal of infectious waste.

With our medical disposal service, you can expect:

* **on site consulting**
* **a complete line of packing supplies**
* **outside storage containers**
* **trained, courteous employees**

Service is our priority.

Ed's MED - P.O.Box 6324 Charleston, WV 25362 - (304) 342-4867 - (800) 345-4660

MSS Executive Committee meeting very productive

I write this letter still filled with the excitement of attending the WVSMA Annual Meeting at The Greenbrier. It was a very productive few days enhanced by the sumptuous surroundings of one of the nation's most prestigious resorts. My exercise program has had to double to try to lose the weight I gained from eating all that wonderful food.

The WVSMA Medical Student Section (WVSMA-MSS) Executive Council meeting was held in conjunction with the WVSMA's Annual Meeting and was extremely effective in generating new plans and putting them into action. We were able to establish three new committees to deal with the ever-increasing activities of our section.

The first new committee we have organized is a Finance Committee that will plan the budget for the MSS. This committee will be chaired by Myra Wilkerson, MSS secretary/treasurer, and includes the treasurers from all the component societies (medical school campuses). This committee's job was made much easier by the generosity of Dr. Robert P. Pulliam, who bestowed a monetary gift to our section in recognition of our marked increase in membership during his year as president of the WVSMA.

A Long-Range Planning Committee was the second new committee we formed, and it will be chaired by David Artz, MSS vice-president. The members of this committee will include the presidents from each component society, and we are particularly excited about the opportunities that long-range planning will bring to our organization.

In addition, we also established a committee to plan the program for our annual meeting that will be held in Morgantown in January. The necessity of this committee arose when Dr. James Comerci, the new president of the WVSMA, generously offered to allow the Medical Student Section to plan its own program during the WVSMA's Mid-Winter Clinical Conference, which will also be held in Morgantown in January. The Program Committee will be chaired by Kim Oxley, a councilor from the Marshall University School of Medicine.

At the meeting, we were also pleased to announce the new two, three and four-year memberships which the WVSMA is now offering for medical students at discounted rates. These memberships will allow members to continue receiving the AMA Drug Evaluation book which is given to second-year medical students who are four-year members of the AMA. As most of you know, by becoming a member of the WVSMA-MSS, you will automatically become a member of the AMA. For more information on membership, please call Donna Webb at 1-800-257-4747.

In addition to our meeting, I was very pleased to attend many of the other events at the WVSMA's Annual Meeting. A special highlight for me was the address of Joseph T. Painter, M.D., president of the American Medical Association, who discussed some of the issues surrounding health care reform. Upon hearing Dr. Painter speak, I was once again reminded of how important it is for us, as future physicians, to begin taking an active role in the WVSMA and the AMA so that we may have a voice in the future of health care.

I would like to thank Dr. Pulliam and Dr. Comerci for their support of the Medical Student Section. Without their continued support, I am sure that our section could not have continued to grow and develop as it has. I am sure that you all join me in wishing Dr. Pulliam continued success as he remains an important voice in the West Virginia Legislature. Furthermore, we look forward to working with and supporting Dr. Comerci in his new role as president of the WVSMA.

Our next Council meeting will be Wednesday, September 22 at 2 p.m. at the WVSMA Office in Charleston. Each campus should try to send two councilors to this meeting. I look forward to the reports of the newly formed committees at that meeting, and we will strive you to keep you informed.

Mark S. Wright, MS IV
President, WVSMA-MSS

HEALTHTALK™

ICN is proud to offer **HEALTHTALK™** to the medical community of West Virginia. This exclusive program was designed to show our appreciation to the many individuals that have contributed to the health and welfare of the residents of West Virginia. To learn more about the special benefits **HEALTHTALK™** members enjoy, please call your local ICN office.

INDEPENDENT CELLULAR NETWORK

a Wireless One Network company

CHARLESTON	LOGAN	HUNTINGTON	WHEELING	PARKERSBURG
925-4000	752-5200	525-4101	233-5600	485-5600

THE SIGN *of the* Times

Because there will be times when *just doing it* will mean just taking care of yourself. It will mean admitting, "I'm hurt and I need help." It will mean just calling

THE SPORTS MEDICINE INSTITUTE.

"Professional, experienced, responsive medical care"

Because there will be *those times*...

Morgantown Physical Therapy Associates

MONONGALIA GENERAL HOSPITAL CAMPUS

(304) 599-2515

Morgantown Orthopedic Associates

200 WEDGEWOOD DRIVE

(304) 599-0720

Joseph G. Feghali, MD

Glaucoma Consultation and Surgery

Member of the American Glaucoma Society

- Specializes in pediatric and adult glaucoma
- Computerized optic nerve tomography: a quantitative scanning laser method to assess optic nerve tissue damage from glaucoma
- Glaucoma drainage implants: an established new surgical procedure for refractory and high-risk glaucoma cases

Joseph G. Feghali, MD - 2000 Hampton Center, Suite D - Morgantown, WV 26505
For appointments, call: (304) 599-6627 or (800) 333-6627

Obituaries

George Thomas Evans, M.D.

Dr. George T. Evans, 81, of Myrtle Beach, S.C., and formerly of Fairmont, died May 27 at Grand Strand General Hospital in Myrtle Beach.

A native of Fairmont, Dr. Evans graduated from Fairmont State College, received his pre-med degree from West Virginia University and obtained his medical degree from Rush Medical College at the University of Chicago in 1937. He did his internship at the Henry Ford Hospital in Detroit and went into private practice in obstetrics/gynecology in Fairmont in 1939.

Dr. Evans served as a major in the U.S. Army for five years during World War II, and after the war he returned to his practice in Fairmont.

Active in many community organizations, Dr. Evans was a former president of the Rotary Club, the Marion County Board of Education, and the Marion County Medical Society. He had been a member of the WVSMA since 1939 and served on Council for many years.

Survivors include his wife, Anneta "Sally" Wegerich Evans; two sons, Dr. George Thomas Evans Jr. of San Francisco and Frank Kinsey Evans of Ocala, Fla.; one daughter, Sally Kallam of Huntington, Texas; and two granddaughters.

He was preceded in death by two brothers, Bill Evans and Frank Kinsey Evans; and one sister, Jane Evans.

J. Dennis Kugel, M.D.

Dr. J. Dennis Kugel, 76, of Charleston, died August 14 at home after a long illness.

Born in Chicago, Dr. Kugel received his medical degree from Northwestern University Medical School in 1944. He interned at Passavant Memorial Hospital in Chicago and then remained in Chicago to complete his residency at Augustana Hospital.

Dr. Kugel was a 43-year resident of Charleston who specialized in radiology. He was named a Fellow of the American College of Radiology in 1969, and also served intermittently on the West Virginia Occupational Pneumoconiosis Board during his career.

A former director of radiology at Thomas Memorial, St. Francis, McMillan, Kanawha Valley Memorial and Staats hospitals, Dr. Kugel also was a former president of the medical staffs at Thomas Memorial and Staats. A member of the WVSMA since 1950, Dr. Kugel was also a member of the Kanawha County Medical Society, the West Virginia Radiologic Society, the American College of Radiology, the AMA, the Radiologic Society of North America, and the American College of Nuclear Physicians.

Dr. Kugel was a World War II veteran of the U.S. Army Medical Corps. He was a member of First Presbyterian Church.

Survivors include his wife, Marjorie L.; sons, Dr. Jeffrey A. of Quincy, Ill., and Thomas B. at home; daughter, Julie A. Nickelsen of Berkley, Calif.; and five grandchildren.

The family suggests memorial contributions be made to Kanawha Hospice Care or the Salvation Army.

SUPPORT RESEARCH.
It Works Wonders.
American Heart Association

Quirico Santiago, M.D.

Dr. Quirico Angel Siongco Santiago, 58, of Parkersburg, died August 6 at his residence after a four and a half year fight against cancer.

Born in Manila, Philippines, Dr. Santiago received his bachelor of arts at Ateno de Manila, a Jesuit University, and his medical degree from the University of St. Thomas in Manila in 1960. After serving one year of his internship at Clark Air Force Base, he was named the outstanding intern in 1960.

In addition, Dr. Santiago served an internship and residency at Baltimore City Hospital and Johns Hopkins Hospital from 1960-67. He served a residency in cardiovascular surgery at St. Louis University Hospital from 1967-68.

Dr. Santiago opened his practice in general surgery in Parkersburg in 1968, where he operated until April 1989 when he had to retire due to his illness. After being stricken with lung cancer, he continued to help others at the free cancer clinic that he established at his office.

Dr. Santiago was a member of St. Margaret Mary Catholic Church of Parkersburg, the American Board of Surgery and the AMA. In addition, Dr. Santiago had been a member of the WVSMA since 1969, and was a member of the Parkersburg Academy of Medicine and a Fellow of the College of Angiology.

Survivors include his mother, Aurea Siongco Santiago; his wife, Teresa Boso Santiago; six sons, JoJo of Washington, D.C., Mike and Ben both of California, and Joshua, Christopher and Peter all of Parkersburg; two daughters, Gigi Gardell of Pennsylvania and Christina of New York; two sisters, Cora Santiago David of Parkersburg and Lucilla Santiago Perez of Manila; five grandchildren; and several nieces and nephews.

Dr. Santiago was preceded in death by one brother.

Memorials are preferred to the American Cancer Society, 4420 Rosemar Road, Suite 201, Parkersburg, WV 26104-9407.

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal*.

Postmaster send form 3579 to the *West Virginia Medical Journal*, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal*, P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Special Section • Convention Report
Photo Highlights 428-435
1993 Resolutions 436
Annual Reports 438

Scientific Newsfront
The changing pattern of early breast cancer and its primary management at CAMC 442
Management of deep vein thrombosis of the lower extremity in pregnancy 445
Manuscript Guidelines 447
Breast cancer - A medical disease? Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of West Virginia University 448

President's Page
"The Plan" means Americans must make tough choices . . . 454

Editorial
Health care disaster 455

Our Readers Speak
Actual courses??? 456
Time to set term limitations 456

In My Opinion
Why I'm joining the physicians union 457

Special Departments
General News 460
Continuing Medical Education 464
Medical Meetings/Poetry Corner 465
Bureau of Public Health News 466
Robert C. Byrd Health Sciences Center News 468
Marshall University School of Medicine News 470
Obituaries 472
Society News 472
1992 Annual Audit 474
Classified 477
October Advertisers 478

Front Cover

A picturesque fall setting is found at the Glade Creek Grist Mill in Babcock State Park. Photo courtesy of *Scott Durham* of Pineville, W.Va.

The WVSMA / WVACP

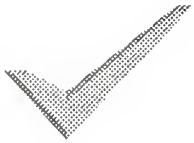
1994 Mid-Winter Seminars and Scientific Conferences

are just around the Corner

January 20-23, 1994

Lakeview Conference and Resort

Morgantown, West Virginia



Mark Your Calendar and watch for upcoming announcements.

The WVSMA's Mid-Winter Sessions will be held in conjunction with the Third Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. Call the WVSMA at (304) 925-0342 for more information.

The Changing Environment of Medicine

Special topics to be featured include:

Joint Sessions

"Polymyalgia Rheumatica and Giant Cell Arteritis"
"Management of Complex Cardiac Dysrhythmias"
"Recent Advances in Gastroenterology"
"Health Care Decision Making in West Virginia: The Effect of the New Statutes"

Physician/Public Session

"Health System Reform: The State View"

Controversies in Medicine

"Physician Assisted Suicide"
"Estrogen Replacement Therapy"

Environmental Medicine/Patient Communication

"Acute and Chronic Effects of Environmental Exposures"
"The Physician as a Source of Environmental Information"
"Patient and Community Information Needs"
"Clinical Implications of Environmental Exposures"

Potpourri of Topics

"The Role of Carotid Endarterectomy"
"Ambulatory HIV"
"Norplant"
"Identifying Adolescent Alcoholics"

Convention Report

SPECIAL SECTION

Highlights of the West Virginia State Medical Association's 126th Annual Meeting

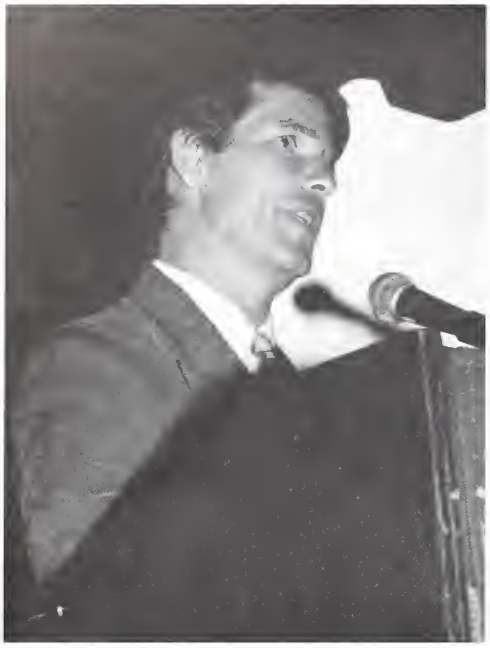
August 18-21, 1993

The Greenbrier
White Sulphur Springs, West Virginia

We wish to thank the participants of the WVSMA's 126th Annual Meeting.

Your commitment and support strengthens the Association and is vital to its continuing success.

Photo Highlights



Dr. Tony Kelly, director of Emergency Services at Beckley Appalachian Regional Hospital and Welch General Hospital, was one of the lecturers for this year's General Session on how "Doctors View Today's Dysfunctional American Family."

Dr. Alva Deardorff updated the Council members about the activities of WESPAC.

At the Presidential Reception, Dr. Darryl Landis, a delegate and Council member from the Preston County Medical Society, talked with Dr. James Helsley, who was elected vice president of the WVSMA during the Annual Meeting.

Pacita Salon, president of the WVSMAA from 1992-93, was filled with emotion as Dr. Robert Pulliam, WVSMA president from 1992-93, presented her with the Presidential Citation for her outstanding efforts in raising the awareness of domestic violence issues.

Dr. Michael Thase of the University of Pittsburgh addresses a participant's question at the panel discussion following the presentations for the General Session. Dr. Lee Neilan (left) moderated this session and the other panelists included Dr. Glen Aukerman, Dr. George Comerci, Delegate Sharon Spencer, Dr. Ahmed Faheem, Dr. Edward Pinney Jr. and Dr. David Morgan.

While visiting the Exhibit Center, Dr. David Morgan couldn't help but laugh at Dr. Thomas Chang, who was trying out a new surgical chair with the assistance of representatives from McLain Surgical Supply, Inc.

After being named the Rural Health Physician of the Year, Dr. Robert Walker of Marshall University visited with Dr. Joseph Locascio III of Huntington in the Exhibit Center.

At the popular Lunch and Learn on "Physicians' Responsibilities in Patient Matters Involving Family Violence," Dr. Stanley Lucas, president of the Ohio State Medical Society, showed participants the publication his association created to help educate their members and the public about domestic violence.

Dr. William Beeson, president of the Indiana State Medical Association, brought his family with him to The Greenbrier to enjoy the festivities.

Dr. Charles Merritt and his wife, Mary Martha, pose with the plaque Dr. Merritt received from Wyeth-Ayerst for his outstanding contributions to community service throughout his career.

Photo Highlights

AMA President Dr. Joseph Painter delivered his address, which was entitled "Health Care Reform: Medicine at the Brink," during the Second Session of the WVSMA House of Delegates.

Members of the WVSMA's Publication Committee gathered for a group portrait following their annual meeting. Pictured from left to right are Dr. Linn Mangano, Dr. Robert Marshall, Dr. John Hartman, Dr. Harvey Reisenweber, Chairman Dr. Stephen Ward, Dr. David Morgan and Dr. Joe Jarrett.

Dr. George Comerci, president-elect of the American Academy of Pediatrics, delivered this year's Edmund B. Flink Address on the subject of physician burnout. Dr. Comerci was also one of the featured speakers for the General Session on "Doctors View Today's Dysfunctional Family."

Delegate and Council member Richard Kerr of the Monongalia County Medical Society attended the meeting with his wife, Linda, who is co-chairman of the WVSMAA's Legislation Committee.

Dr. Robert Pulliam, president of the WVSMA from 1992-93, congratulates Mark Wright, president of the WVSMA's Medical Student Section, as he presents him with a check for $500 in honor of the Medical Student Section's dramatic increase in membership during the past year.

Dr. Generoso Duremdes and his wife, Dr. Janelle Duremdes, made a striking couple as they moved across the floor at the "Spectrum of Music" dance.

Therese Cox, the medical reporter for the Charleston Daily Mail, interviewed Dr. James Comerci, the WVSMA's new president, during the Annual Meeting about his views on a variety of health care issues.

At the luncheon for WVSMA component and specialty society presidents, WVSMA past presidents, 50-year graduates and visiting state presidents, WVSMA Past President Dr. William Gilmore spoke to the guests about his retirement activities.

(Left) Dr. Norman Taylor and his wife, Dr. Nancy Webb, relax at the dance which was held on Friday evening during the Annual Meeting.

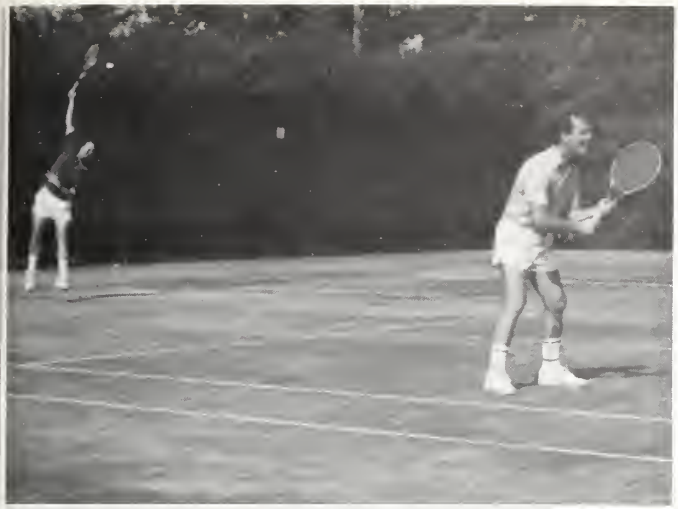
Photo Highlights

Dr. Bill Atkinson and his wife, Carolyn, take a break after strolling the beautiful grounds of The Greenbrier.

WVSMA President-Elect Dr. Dennis Burton lines up a chip shot during the golf tournament.

Dr. Martin Reiter and his wife, Ree Cook-Reiter, teamed up with Dr. Harry Shannon and his wife, Judith, for the golf tournament.

The winners of the golf tournament Robert Kidd, Tom Mitchell, Ed Hines and Dr. Estelito Santos happily hold their trophies at the awards presentation in the Exhibit Center.



As his partner Jug Moser serves, Dr. Barton Herschfield prepares for the ball to return during the tennis tournament.

The winners of the women's tennis tournament gathered for a victory photo. Pictured on the front row are Sylvia Gogo and Wha Ja Chang, and in the back row are Sandy Maiolo, Audrey Warden and Linda Elliott.

Theresa Artip sets up a shot in the fast-paced volleyball game.

The members of the winning volleyball team proudly display the t-shirts that Sandoz Pharmaceuticals contributed for the players.

Photo Highlights

Pacita Salon, president of the WVSMA Alliance from 1992-93, presided over the WVSMAA's business meeting during the convention.

A program on "Active Parenting" was conducted by Novella Woodrum, a counselor for The Family Center, Inc. in Beckley, for the Alliance members.

AMA Alliance President Mary Hanson addressed the WVSMA Alliance at their Annual Meeting.

The Alliance officers for 1993-94, Vickie Helsley, treasurer; Joy Johnson, recording secretary; Judy Bofill, vice president; Sue Bryant, president-elect; and Carole Scaring, president; were installed by AMA Alliance President Mary Hanson at the Second Session of the WVSMAA's House of Delegates.

The Harrison County Medical Society Alliance was the component society which raised the largest amount of funds for AMA-ERF this past year, and Harrison County members Subhra Datta and Sue Bryant proudly accepted the award for this honor from Linda Elliott, AMA-ERF chairman.

New WVSMA Alliance President Carole Scaring addressed the members of the WVSMA House of Delegates during their Second Session.

Outgoing WVSMA President Dr. Robert Pulliam was delighted when his successor Dr. James Comerci presented him with a special honorary degree for all the "unique" special talents he gained as a delegate in the West Virginia Legislature during the past session.

At the reception honoring the newly installed officers of the WVSMA and WVSMAA, WVSMA President Dr. James Comerci celebrated his inauguration with his secretary, Ethel Pritsos; his daughter, Michele; his wife, Lynn; his daughter, Jennifer; and his nurse, Miriam Deinhardt.

New WVSMA Vice President Dr. James Helsley enjoyed the Saturday evening reception with his wife, Vickie.

New WVSMA Alliance President Carole Scaring celebrated her inauguration with her husband, Dr. William Scaring, and Kathy Fortunato, health projects chairman for the WVSMAA, and Janie Altmeyer, WVSMAA parliamentarian who was president of the WVSMAA from 1991-92.

1993 Resolutions

Resolution No. 1 (not adopted)

WHEREAS, the National Institutes of Health and the Office of the Surgeon General of the United States for many years have maintained that the use of tobacco products causes severe and permanent illness, and

WHEREAS, recent studies have shown that ambient smoke from tobacco products also is harmful, therefore be it

RESOLVED, that all meetings of the Raleigh County Medical Society will be smoke free henceforth and in the future and that this resolution should be forwarded to the West Virginia State Medical Association for action by the House of Delegates at its next regular meeting.

Resolution No. 2 (adopted)

WHEREAS, West Virginia is designated as an area of physician shortage by the federal government, and

WHEREAS, the State of West Virginia has discouraged physicians to come to West Virginia or to stay in the state because of such legislation as the Medicaid Enhancement Tax, UMW not paying bills, lack of tort reform, the Blue Cross/Blue Shield bankruptcy, and other physician disincentive programs, therefore be it

RESOLVED, that the West Virginia State Medical Association encourage the Legislature to pass laws to create a more stable climate for businesses and the medical community.

Resolution No. 3: (adopted as amended)

WHEREAS, the WESPAC is the political action committee voice of the West Virginia State Medical Association, and

WHEREAS, WESPAC has become less effective, and

WHEREAS, WESPAC needs to be a stronger voice for the physicians, therefore be it

RESOLVED, that the West Virginia State Medical Association suggest ways to strengthen WESPAC.

Resolution No. 4: (adopted as amended)

WHEREAS, West Virginia citizens should understand the complexity of Health Care Reform, and

WHEREAS, physicians rightly are concerned that reform may destroy the good aspects of the current systems, and

WHEREAS, physicians are concerned about rising health care costs, and

WHEREAS, physicians who are on the front line understand the complexity of providing health care, therefore be it

RESOLVED. that physicians should be allowed more input in Health Care Reform in the State of West Virginia, and be it further

RESOLVED, that the West Virginia State Medical Association develop a program to educate the citizens of West Virginia on Health Care Reform.

Resolution No. 5: (adopted)

WHEREAS, as the state and federal levels of government have proposed some type of tort reform, and

WHEREAS, the State of California has a model for tort reform that West Virginia could adopt, and

WHEREAS, the State of West Virginia has had no tort reform in past years, and

WHEREAS, physicians need tort reform to reduce the cost of medical care, therefore be it

RESOLVED, that the West Virginia State Medical Association support tort reform at the federal level.

Resolution No. 6: (substitute resolution adopted)

WHEREAS, clinical studies underscore the prevalence of domestic violence and its relationship to continued or repeated trauma and consequent medical and psychiatric problems; and

WHEREAS, more than half of all non-fatal assaults result in injury, and 10% of victims require hospitalization or emergency medical treatment; and

WHEREAS, a medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur; and

WHEREAS, most physicians will encounter cases of domestic violence in their practices and must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and/or report domestic violence; therefore be it

RESOLVED, that the WVSMA work with the Alliance to encourage local medical schools to provide information and training to medical students on all aspects of domestic violence.

Resolution No. 7: (substitute resolution adopted)

WHEREAS, almost 500,000 United States citizens die yearly due to tobacco-related diseases; and

WHEREAS, the cost of tobacco use in the United States is $65 billion or about $221 per person; and

WHEREAS, the tobacco industry gives large political contributions to members of Congress and

WHEREAS, members of Congress have suppressed legislation limiting tobacco availability, cutting tobacco subsidies and raising tobacco taxes which could be used to finance health care; therefore be it

RESOLVED, that the West Virginia State Medical Association submit a resolution at the 1993 American Medical Association Interim Meeting that the AMA publicly condemn members of the United States Congress who accept gifts or contributions of any kind from the tobacco industry, and identify those members who continue to receive such gifts and contributions; and be it further

RESOLVED, that the AMA call upon the United States Congress to support the legislation of the AMA Coalition on Tobacco Control.

Resolution No. 8: (substitute resolution adopted)

WHEREAS, over 4,000 West Virginians die yearly because of tobacco related diseases; and

WHEREAS, the cost of tobacco use in West Virginia is over $500 million averaging about $305 per person; and

WHEREAS, the tobacco industry gives large political contributions to Governor Gaston Caperton and members of the West Virginia Legislature; and

WHEREAS, as the result of these contributions, Governor Caperton and the West Virginia Legislature have suppressed legislation that would limit the availability of tobacco products and raise taxes on tobacco to be used to finance health care; therefore be it

RESOLVED, that the West Virginia State Medical Association publicly condemn Governor Gaston Caperton, members of the Legislature and other elected officials who accept gifts or contributions of any kind from the tobacco industry and identify those who continue to accept such gifts or contributions; and be it further

RESOLVED, that the WVSMA call upon Governor Gaston Caperton and all members of the West Virginia Legislature to support legislation offered by the West Virginia Tobacco Control Coalition and the Healthy West Virginia Coalition.

Resolution No. 9 (referred to Council for decision and action)

WHEREAS, physicians provide a significant amount of uncompensated care yet are rarely compensated for that contribution; and

WHEREAS, there are many programs available in the state to provide this care; and

WHEREAS, the state physicians can make a significant impact on the care of those under-insured; therefore be it

RESOLVED, that the Council and Executive Committee of the West Virginia State Medical Association appoint a task force to coordinate a program with the State of West Virginia administration to develop a means so that these patients can be identified and adequately cared for without consideration of their ability to pay.

A Dollar A Day

will help things go your way!

$365 Club

WESPAC has a new club - the $365 Club - or A Dollar A Day. Just think about it, a dollar a day can better help reform the health care system and protect your rights as physicians as well as the rights of your patients. Don't wait, the time to act is now!! **Send your personal check to WESPAC and become involved!**

WESPAC
P.O. Box 4106
Charleston, WV 25364

Annual Reports

Committee on Cancer

Meetings of the Cancer Committee were held August 21, 1992, during the WVSMA's Annual Meeting at The Greenbrier in White Sulphur Springs; and during the WVSMA's Mid-Winter Clinical Conference on January 23, 1993, at the Charleston House Holiday Inn in Charleston.

Nancye Bazzle, program director of the West Virginia Bureau of Public Health's Cancer Screening Program, presented the program's goals which included increasing the capacity and utilization of screening for breast and cervical cancer in West Virginia. The target group is minority women who are older, have low incomes, are uninsured, underinsured or at-risk. Another goal she discussed was to develop a culturally sensitive and effective statewide public education program that will promote breast and cervical cancer screening among all age-appropriate and inadequately screened women in West Virginia.

Jan Devier of the Breast and Cervical Cancer Program at the West Virginia Bureau of Public Health stated that the program's quality assurance goals were to assure that all West Virginia women receive breast and cervical-related care that meets current professional standards, and to monitor the contract laboratory to assure compliance with all federal regulations and terms of the contract. A total of 42 mammography facilities have applied for ACR (American College of Radiology) accreditation, and 26 of the facilities had been accredited at that time.

State Epidemiologist Loretta Haddy reported that Senate Bill 272 passed on March 16, 1992. This bill provides for the establishment of a West Virginia statewide cancer tumor registry. For the first year, a budget of $70,000 is allotted, and $125,000 is allocated for the second year. An Advisory Committee on Cancer was established consisting of representatives from the WVSMA; the West Virginia Hospital Association; the American Cancer Society, West Virginia Division; the American Lung Association of West Virginia; the West Virginia Association of Osteopathic Medicine; the West Virginia Nurses Association; the Mary Babb Randolph Cancer Center; and, at the discretion of the director, any other individuals directly involved.

Beverly Crowder Keener of the Breast and Cervical Cancer Incidence Registry reported that 61 hospitals are participating in the Cancer Tumor Registry. Eleven hospitals have cancer registries which are approved by the Commission on Cancer of the American College of Surgeons. They are in the process of establishing a reciprocal agreement with neighboring states for the data exchange with West Virginia.

Mrs. Keener explained that there were 1,036 cases of invasive carcinoma of the breast diagnosed among female residents of West Virginia, with an additional 104 cases of carcinoma in situ and 336 deaths in 1991. She also stated that there were 115 cases of invasive cancer of the cervix uteri and 385 cases of carcinoma in situ diagnosed and 42 deaths of carcinoma of the cervix.

Kay Arthur Smith, who is also with the Breast and Cervical Cancer Screening Program, reported that there were 21,000 cases screened since April 1, 1991. There were 20 cases of carcinoma and 104 cases of carcinoma in situ of the breast. Five invasive cervical carcinomas were diagnosed and 243 cervical biopsies were dysplasia.

Dr. Mendoza announced that the Patient Care Evaluation Studies on Pancreatic Cancer have been mailed to hospital registrars and central registries throughout the country by the Commission on Cancer of the American College of Surgeons. This confidential study includes patients initially diagnosed with pancreatic cancer from 1985-1990.

Dr. Mendoza also announced that Dr. John Pearson's paper concerning mammography in West Virginia was to be published by the *American Journal of Preventive Medicine* in the early spring of 1993.

Mrs. Thomas Covey reported on the activities at the Mary Babb Randolph Cancer Center including PDQ. There were over 1,200 telephone calls received in 1991 which included inquiries on the accredited mammography facilities by the A.C.R. A contract was submitted to N.C.I. for the coming year which will include Virginia and Ohio.

Dr. Jubelirer reported on the Breast Cancer Prevention Trial with tamoxifen. Thirty-one women were entered in this study by January 1993, with a target of 50 women by May 1993. Physicians who are interested in entering patients in this study were asked to contact Dr. Jubelirer at 348-4337.

Dr. Raich reported on the Bone Marrow Transplantation Program at the West Virginia University Health Sciences Center.

Respectfully submitted,
Catalino B. Mendoza Jr., M.D., F.A.C.S.
Chairman, WVSMA Committee on Cancer

Council

The August 1992 meeting of the Council addressed the following items:

CNA announced a 12.6 percent increase in medical malpractice premiums. Although it was recommended that CNA continue to be endorsed, it was noted that there was grave concern about this increase.

The Medicaid Enhancement program was discussed and it was noted that a resolution addressing future provider taxes would be considered by the House of Delegates.

Discussion was held concerning the West Virginia Health Care Planning Commission and the presentation on this subject on Thursday, August 20, 1992.

It was determined after a legal and financial analysis by the WVSMA's accountants that there was no advantage at this time to create a 501-C-(3) foundation.

The November meeting addressed the following issues:

Discussion was held concerning reconstitution of the WESPAC due to the fact that the number of congressional districts has changed from four to three.

A report on the activities of the Auxiliary was given by Pacita Salon, president of the WVSMAA.

An update on the Blue Cross/Blue Shield legislation was given. The total legal fees to WVSMA for this protracted effort has reached about $75,000. However, as a result of our activities, the anticipated payment to physicians in this settlement has gone from 8 to 10 cents on the dollar, to about 50 cents on the dollar.

The 1993 proposed budget was approved.

The January 24 meeting addressed the following topics:

It was reported that the 1992 financials showed a final figure of $16,000 revenue over expenses.

The Council directed that George Rider negotiate a new mortgage loan on the WVSMA building. Nominees for the reconstituted WESPAC Board were presented and approved.

It was reported that a list of alternative funding programs for Medicaid has been developed.

The AMA's Health Access America program was used as the model for WVSMA's Health Reform Legislation which was to be introduced at the 1993 Legislature; and it was presented to the House of Delegates at their special session at the conclusion of the WVSMA's Mid-Winter Clinical Conference in Charleston.

There was a conference call meeting of the Council on March 17, 1993, to address the pending Medicaid tax issue. A motion was made to oppose any tax, but if a provider tax is imminent, that it not exceed 2% of gross receipts for physicians.

The June 27 meeting addressed the following items:

A report of the Constitution and Bylaws Committee addressing six items for change was presented.

Legal counsel reviewed options available to the WVSMA addressing possible litigation concerning the Medicaid Provider Tax Act SB-2.

Dr. Ted Lewers, AMA trustee, attended this meeting and reviewed the value of organized medicine, i.e., AMA, WVSMA and component societies, and their chance of impacting on changes in the practice of medicine. He emphasized that a unified voice by medicine was paramount in this effort.

A report on the 1993 AMA Annual Meeting was presented.

Highland Hospital

Inpatient Treatment Program for Schizophrenia or Schizoaffective Disorders

A treatment program is available with an investigational medicine for acute exacerbation of Chronic Schizophrenia or Schizoaffective Disorder.

This clinical trial is open to healthy males or healthy sterile females from 18-65 years of age. Patients must be able to give informed consent and agree to a four week hospital stay.

If medication is effective and participants wish to continue out-patient treatment with the medication, it can be provided for a one-year period. There is no charge for the inpatient or out-patient programs.

For more information, call: Charles C. Weise, M.D. at (304) 925-2159.

Highland Hospital is located at 56th Street and Noyes Avenue, S.E., Charleston.

Laser Surgery Seminar X

SATURDAY, OCTOBER 30, 1993
CHARLESTON MARRIOTT

EYE • ENT • GYN • COSMETIC • CHEST • DERMATOLOGY • GENERAL SURGERY • UROLOGY • VASCULAR • ENDOSCOPY

A comprehensive update on the biophysics and uses of various lasers in surgery for physicians, nurses, nurse anesthetists and other health professionals

FACULTY

Francisco T Aledia, MD
Peter K Americo, MS, CCC-Sp
James P Boland, MD
Christopher J Daly, MD
Harakh V Dedhia, MD
Paul H Fulcher, Jr, MD
Richard C Haydon, MD
Haskins K Kashima, MD
Romeo Y Lim, MD
Bernard J Luby, MD
Robert E O'Connor, MD
Robert E Pollard, MD
Joseph T Skaggs, MD
George R Valentini, MD
R Austin Wallace, MD
Stafford G Warren, MD
Mary Jane Willis, PA
Moseley H Winkler, MD

SPECIAL GUEST OF HONOR

STEPHEN J WETMORE, MD

SPONSOR

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
The Laser Surgery Center

CO-SPONSOR

DEPARTMENT OF SURGERY, ROBERT C BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY
Charleston Division
CHARLESTON AREA MEDICAL CENTER

CREDIT

4.5 CME Units, 4.5 CE Units, AANA, .45 CEUs

FOR REGISTRATION INFORMATION, CONTACT:
ROMEO Y LIM, MD, SEMINAR DIRECTOR
MARY JANE WILLIS, PA, PROGRAM COORDINATOR
(304) 353-0227 or 1-800-642-3049 (WV)

bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 μg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy; Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other:* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough.*

Clinical Laboratory Test Findings; Serum Electrolytes: See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular:* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established. *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses:* Transient blurred vision, xanthopsia.

* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

Dist. by

MERCK & CO., INC.
West Point, PA 19486, USA

Issued June 1993
7432318

Printed in USA

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

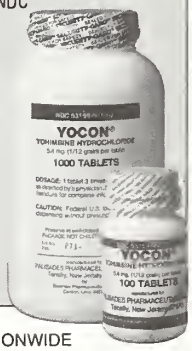
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

AVAILABLE AT PHARMACIES NATIONWIDE

PALISADES PHARMACEUTICALS, INC.
64 North Summit Street
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

The changing pattern of early breast cancer and its primary management at CAMC

STEVEN J. JUBELIRER, M.D.
Director, Cancer Care Center of Southern West Virginia, Charleston Area Medical Center; and Clinical Professor, West Virginia University School of Medicine, Charleston Division
JASON I. SMITH, MS III
West Virginia University School of Medicine
MOUNA GHARIB, MS III
West Virginia University School of Medicine

Abstract

To gauge the impact of screening mammography and the results of clinical trials on the pattern of primary surgical care of early breast cancer, tumor registry data from the Charleston Area Medical Center for 1980-81 was compared to tumor registry data at the hospital for 1990-91. Over the course of 10 years, there was a significant increase in the proportion of patients with T1 tumors (52% vs. 66%, p = .004), a significant increase of cases diagnosed by mammography alone (6% vs. 34%, p < .001), a significant decrease in the proportion of patients with positive axillary nodes (41% vs. 28%, p = .016), and a significant increase in the proportion of patients undergoing breast-sparing procedures (4% vs. 16%, p = .003). However, the percentage of breast-sparing operations at CAMC from 1990-91 was lower than the number reported in the National Cancer Data Base of 1988 (16% vs. 29%). A future study to assess reasons for patient selection of mastectomy or local excision is being planned.

Introduction

During the past 10 years, several factors should have had a dramatic impact on both breast tumor size at diagnosis and on the choice of primary surgical treatment.

The development of low-dose sensitive mammography led to recommendations for yearly screening of asymptomatic women over age 50 (1). Numerous studies have shown that the discovery of breast cancers before they are palpable results in the treatment of patients with smaller tumors that have a better prognosis (1-4).

Another significant development has been the compelling evidence from clinical trials that disease-free and overall survival rates in early breast cancer were similar for both mastectomy and breast-conserving procedures (5-7).

To determine to what extent these factors actually influenced the diagnosis and treatment of breast cancer at the Charleston Area Medical Center, we compared patients treated from 1980-81 to those seen from 1990-91 with respect to the proportion diagnosed by mammography and the proportion undergoing breast-conserving surgery. In order to assure ourselves that CAMC's experience from 1980-81 and from 1990-91 mirrored national trends, we compared CAMC tumor registry data to those of the American College of Surgeons (ACOS) National Survey on Breast Cancer (8), and to the National Cancer Data Base (NCDB) survey compiled in 1977 and 1988 respectively.

Materials and Methods

The data used in this analysis was derived from the tumor registry patient abstracts, pathology reports, and patient charts. The minimum information necessary for each case to be considered for evaluation included patient age, size of tumor, number of lymph nodes positive for tumor, the type of surgery performed, and the method of diagnosis.

In order to have a sufficient number of cases for comparison, we pooled the patient data from 1980, 1981, 1990

TABLE 1. Comparison of Breast Cancer Patients at CAMC from 1980-81 and from 1990-91

	1980-1981	1990-1991
Characteristic		
Number of patients	132	191
Median age (years)	58	60
Age range (years)	26 - 80	30 - 84
Surgery %		
Mastectomy	96.2	84
Breast conserving surgery and radiotherapy	2.3	13
Breast conserving surgery	1.5	3
Size of Tumor %		
T1a (≤ .5 cm.)	0	7.9
T1b (.5-1 cm.)	14.4	15.7
T1c (1-2 cm.)	37.9	41.9
T2 (2-5 cm.)	46.2	33.5
T3 (≥ 5 cm.)	1.5	1.0
Axillary Nodal Status		
Negative	59	72
Positive	41	28
1-3 positive	48	66
4-10 positive	39	28
> 10 positive	13	6
Method of Diagnosis		
Patient alone	76.3	49
Mammography alone	6.1	34
Physician	17.6	17

TABLE 2. Comparison of Types of Surgery and Tumor Size of Breast Cancer of Patients at CAMC

Characteristic Radiotherapy	Mastectomy	Breast-Conserving Surgery+
Number of patients	288	35
Median age (years)	20	54
Age range (years)	26 - 85	37 - 67
Tumor size (%)		
≤ 1 cm.	18.8	37
1-2 cm.	39.9	40

TABLE 3. Comparison of the Charleston Area Medical Center Breast Cancer Patients (1980-81) with the American College of Surgeons (ACOS) Study (1977)

	CAMC 1980-1981	ACOS 1977
Characteristic		
Number of patients	132	14,577
Median age (years)	58	58
Type of Surgery %		
Mastectomy	96.2	96.8
Breast conserving surgery (± radiotherapy)	3.8	3.2
Tumor Size %		
≤ 1 cm.	14.4	10.0
1.1-2 cm.	37.9	32.5
2.1-5 cm.	46.7	47.0
≥ 5 cm.	1.5	10.5
Number of Axillary Nodes Positive %		
1-3	48.0	52.0
≥ 4	52.0	48.0

TABLE 4. Comparison of the Charleston Area Medical Center Breast Cancer Patients (1990-91) with the National Cancer Data Base (NCDB) Survey (1988)

	CAMC	NCDB
Characteristic		
Number of patients	191	41,869
Median age (years)	60	62
Type of Surgery %		
Mastectomy	84	71
Breast conserving surgery	16	29
Tumor Size %		
.01-1 cm.	24	28
1.1-2 cm.	42	35
2.1-5 cm.	33	30
≥ 5 cm.	1	7
Number of Axillary Nodes Positive %		
1-3	66	51
≥ 4	34	49

and 1991. The analysis was based on data collected from 132 cases from 1980-81 and 191 cases from 1990-91.

Only histologically documented adenocarcinomas of the breast were included in the study. Tumors were staged according to the American Joint Committee on Cancer (AJCC) or TNM system (10). Tumor size was characterized as follows (TNM system): T1a-less than or equal to 0.5 cm.; T1b-greater than 0.5 cm., less than or equal to 1 cm.; T1c-greater than 1 cm., less than or equal to 2 cm.; T2-greater than 2 cm., less than or equal to 5 cm.; and T3-greater than 5 cm.

For this report, breast-conserving surgery was defined as partial or less than total mastectomy (including segmental mastectomy, lumpectomy, quadrantectomy, wedge resection, nipple resection, excisional biopsy and partial mastectomy that was not otherwise specified), with dissection of axillary lymph nodes. Modified radical, total mastectomy, and extended radical mastectomy were considered together as "mastectomy." All analyses were conducted with programs of the Statistical Analysis System.

Results

The comparison of the two patient groups at CAMC revealed significant differences (Table 1).

In 1990 and 1991, 66% of patients had tumors of 2 cm. or less (T1), whereas in 1980 and 1981, 52% had tumors of similar size (p = .004). Tumors larger than 2 cm. but equal to or less than 5 cm. (T2) comprised 33.5% of the 1990-91 cases and 46% of the 1980-81 cases. Tumors larger than 5 cm. (T3) were seen in 1% of 1990-91 cases and 1.5% of 1980-81 cases.

A breakdown of the tumors within the T1 classification (Table 1) revealed that the 1990-91 cases differed significantly from the 1980-81 cases only in the T1a category. There were no significant differences in the T1b and T1c categories.

When we looked at the choice of primary surgical treatment, we found that 16% the of patients from 1990-91 underwent a breast-conserving procedure as compared to only 4% in 1980-81 (p = .003). The proportion of patients with axillary nodes positive for tumor decreased from 41% in 1980-81 to 28% in 1990-91 (p = .016). The proportion of patients with one to three positive nodes increased from 48% in 1980-81 to 66% in 1990-91, while the proportion of those with four or more positive nodes decreased from 52% in 1980-81 to 33% in 1990-91.

Of the 35 breast-conserving procedures performed in both 1980-81 and 1990-91, 77% were on patients with T1 tumors, while the remaining (23%) were on those with T2 tumors (Table 2). The median age of patients undergoing breast-conserving surgery and mastectomy was 54 years and 60 years respectively.

In order to assure that the pattern of care from 1980-81 at CAMC was not atypical, we compared the hospital data with those reported by the ACOS National Survey of Breast Cancer in 1977 (8) (Table 3). The mean age from both the CAMC study and ACOS study was comparable, however, only 1.5% of patients at CAMC had tumors greater than 5 cm. compared to 10.5% of patients in the ACOS survey. Conversely, the proportion of patients with tumors less than 2 cm. was 52.3% and 42.5% in the CAMC and

ACOS studies, respectively. The proportion of patients undergoing breast-conserving surgery in the CAMC and ACOS study was similar (3.8% vs. 3.2% respectively).

Data from the CAMC tumor registry during the years 1990-91 was compared to data from the NCDB survey (9) published in 1988 (Table 4). The median age from the CAMC and NCDB studies was 60 and 62 respectively. Only 1% of patients at CAMC had tumors greater than 5 cm. compared to 7% of patients in the NCDB study. The proportion of patients with tumors less than 1 cm. was 24% and 28% in the CAMC and NCDB studies respectively. At CAMC, fewer patients underwent breast-conserving surgery than patients in the NCDB study (16% vs. 29% respectively).

Discussion

The results of the CAMC data on early breast cancer from 1980-81 are similar to those of the ACOS study (1977) with respect to the proportion of patients undergoing breast-conserving surgery. The CAMC experience significantly differed from the ACOS study only in the proportion of patients presenting with tumors 5 cm. or larger. One explanation for this difference is that all stages of breast cancer were included in the ACOS survey, whereas only patients with Stage I and II disease were included in the CAMC study.

In comparison with the results of the 1988 NCDB review, the CAMC data from 1990-91 indicated a lower proportion of patients diagnosed with tumors larger than 5 cm. and undergoing breast-conserving surgery. As in the ACOS study, the NCDB review included patients with all stages of breast cancer. The higher proportion of patients in the NCDB review with four or more positive axillary nodes compared to the CAMC study can in part be explained by the higher proportion of patients diagnosed with large tumors (i.e., ≥ 5 cm.).

The comparison of CAMC cases showed that in 1990-91, a larger number of smaller tumors were being detected than was the case in 1980-81. The proportion of women presenting with T1 tumors increased significantly from 52.3% in 1980-81 to 66% in 1990-91. This increase was due to the increase in T1a tumors diagnosed from 1990-91 over 1980-81.

The detection of these smaller tumors was largely due to the increased use of mammography. There was a striking increase in the percentage of cases diagnosed by mammography alone from 1980-81 to 1990-91 (6.1% to 34%, $p < .001$). The lower percentage of patients with axillary node involvement in 1990-91 compared to 1980-81 may be largely due to the smaller number of large tumors and is consistent with the fact that regional spread to axillary lymph nodes correlates highly with tumor size (11).

Despite the increase in breast-conserving procedures at CAMC between 1980-81 and 1990-91, the percentage is lower than that reported in the NCDB study of 1988. A wide geographical variation in the type of breast surgery performed has been noted in several recent studies. Significantly lower rates of breast-sparing surgeries were reported in the southeastern United States compared with the northeast or northwest by Osteen and colleagues (12) using the NCDB records from 1988; by Farrow et al (13) using Surveillance Epidemiology and End Results (SEER) data from 1983 to 1986; and by Nattinger (14) using Medicare claims from 1986.

Other factors such as the biases of the surgeons, the biases of the patients or the educational levels of the patients were not addressed in this study. However, this study may prompt a future study to assess the reasons for selection of mastectomy or local excision.

References

1. Richert-Boe KE, Humphrey LL. Screening for cancer of the cervix and breast. Arch Intern Med 1992;152:2405-11.
2. Baker LH. Breast Cancer Demonstration Project. Cancer 1982; 32:194-225.
3. Shapiro S, Venet W, Strax P, Venet L, Roeser R. Selection, follow-up, and analysis in the Health Insurance Plan Study: a randomized trial with breast cancer screening. Natl Cancer Inst Monogr 1985;67:65-74.
4. Eddy DM. Screening for breast cancer. Ann Intern Med 1989; 111:389-99.
5. Fisher B, Redmond C, Poisson R, et al. Eight-year results of a randomized clinical trial comparing total mastectomy and lumpectomy with or without irradiation in the treatment of Breast Cancer. N Engl J Med 1989;320:822-8.
6. Veronesi V, Saccorzzi R, Del Vecchio M, Banfi A, Clemente C, et al. Comparing radical mastectomy with quadrantectomy, axillary dissection and radiotherapy in patients with small cancers of the breast. N Engl J Med 1981;305:6-11.
7. Sarrazin D, Le M, Arriagada R, et al. Ten-year results of a randomized trial comparing a conservative treatment of mastectomy in early breast cancer. Radiother Onc 1989; 14:177-84.
8. Vana J, Bedwani R, Mettlin C, Murphy GP. Trends in the diagnosis and management of breast cancer in the U.S. From the surveys of the American College of Surgeons. Cancer 1981; 48:1043-52.
9. Menck HR, Garfinkel L, Dodd GD. Preliminary report of the national cancer data base. CA J Phys 1991; 41:7-18.
10. American Joint Committee on Cancer. Manual for staging of cancer. Fourth edition. Philadelphia: JB Lippincott, 1992.
11. Harris JR, Morrow M, Bonadonna G. Cancer of the breast. In: DeVita VT, Hellman S, Rosenberg SA, eds. Cancer principles and practice of oncology. Philadelphia: JB Lippincott Co., 1993.
12. Osteen RT, Steele GD, Menck HR, Winchester DP. Regional differences in surgical management of breast cancer. CA J Phys 1992;42:39-43.
13. Farrow DC, Hunt WC, Samet JM. Geographical variation in the treatment of localized breast cancer. N Engl J Med 1992;326:1097-1101.
14. Nattinger AB, Gottlieb MS, Veum J, et al. Geographical variation in the use of breast-conserving treatment for breast cancer. N Engl J Med 1992;326:1102-7.

Management of deep vein thrombosis of the lower extremity in pregnancy

ALI F. ABURAHMA, M.D.
Professor of Surgery, Chief of the Vascular Section, and Medical Director of the Vascular Laboratory
DENIZ F. BASTUG, M.D.
Chief Resident
EDWARD H. TILEY III, M.D.
Clinical Professor of Surgery
SCOTT M. KILLMER, M.D.
Surgery Resident
JAMES P. BOLAND, M.D.
Professor and Chairman Department of Surgery
Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Area Medical Center, Charleston

Abstract

Deep vein thrombosis (DVT) of the lower extremity during pregnancy is infrequent, but its complication, pulmonary embolism, remains an important cause of maternal mortality. To evaluate the best method of caring for patients with DVT, we reviewed the records of patients at the Charleston Area Medical Center from 1987-1992 who were treated for this condition.

Twelve patients were treated with conventional continuous intravenous heparin for 7 days-10 days followed by subcutaneous heparin until 6 weeks-8 weeks after delivery. The other group consisted of nine patients who were treated with lower dose subcutaneous heparin for 7 days-10 days and maintained as the first group, but a Greenfield filter was inserted for patients with iliofemoral DVT.

The patients who received low-dose heparin and Greenfield filters tended to do better than those who received high-dose conventional heparin treatment. However, since there were so few patients evaluated, further verification is needed.

Introduction

DVT of the lower extremity during pregnancy is not common, but pulmonary embolism which can result, remains an important cause of maternal mortality (1). Acute iliofemoral venous thrombosis is six times more frequent in pregnant women than non-pregnant women, and this is attributed to an increase in coagulation factors and fibrinolysis inhibitors or compression of the inferior vena cava and iliac vein by the pregnant uterus (1). Pulmonary embolism has been reported in 15% to 25% of patients with untreated DVT, resulting in a 12% to 15% mortality (2).

The choice of appropriate therapy for DVT of the lower extremity during pregnancy has been widely debated (1-5). With oral administration, Warfarin (Coumadin) passes through the placenta to the fetus and may cause frequent fetal complications and/or death (5). Heparin, in contrast, does not cross the placental barrier and is considered more effective therapy for deep vein thrombosis (3,4). However, its long-term venous administration during pregnancy may be impractical and increases the risk of osteoporosis, alopecia and neurologic complications (6,7).

Two treatment modalities have been used at Charleston Area Medical Center to treat DVT. The first utilizes conventional heparin anticoagulation therapy before delivery, withdrawal of heparin during delivery, and reinstatement after delivery. This choice provides no assurance that embolic events will not occur during the critical delivery. The other treatment is heparin therapy before and after delivery with insertion of an inferior vena cava filter prepartum (8). A review of published reports on pregnancies in which heparin was administered demonstrates conflicting results, with some showing significant fetal and maternal morbidity and mortality (5), while others conclude that heparin can be safely used in the treatment of DVT in pregnancy (9).

The purposes of this study were to review our recent experiences in the management of DVT of the lower extremity during pregnancy, and to see if lower-dose heparin with or without Greenfield filter insertion for pulmonary embolism prevention has a lower morbidity and mortality rate than the conventional full-dose intravenous heparin therapy.

Patient population and methods

The medical records of patients treated for DVT of the lower extremity during pregnancy at Charleston Area Medical Center during a six-year period (1987-1992) were analyzed. All pertinent data was collected including a past history of DVT, pulmonary embolism, birth control pills, etc. Protein C, protein S, antithrombin III, and lupus anticoagulant levels were reported if done.

The clinical diagnosis of DVT was confirmed in each case by duplex ultrasound and/or phlebography and two treatment protocols were used for treatment of DVT in pregnancy during this period. One was the conventional therapy of continuous intravenous (IV) heparin for 7-10 days (5,000-10,000 units of IV bolus, then the dosage was adjusted by a partial thromboplastin time [PTT] of 2 to 2.5 of the control), followed by 5,000 units of subcutaneous heparin every 12 hours until 6 weeks to 8 weeks after delivery. The other method was non-conventional therapy where patients were treated with lower-dose subcutaneous heparin for 7-10 days with or without Greenfield filter insertion (5,000-10,000 units IV bolus, then 5,000-10,000 units q8-12h subcutaneously with the dosage adjusted for a PTT of 1.5 of the control), followed by 5,000 units of subcutaneous heparin every 12 hours until 6 weeks to 8 weeks after delivery.

In both groups, the subcutaneous heparin was held when active labor commenced and re-administered as soon as possible following delivery. Three patients in the conventional group and two in the non-conventional group, who were not lactating, were maintained on 5 mgs. Coumadin daily for 6 weeks to 8 weeks after delivery instead of subcutaneous heparin. Patients in the non-conventional therapy group with iliofemoral DVT had a Greenfield filter inserted, some for therapeutic and others for prophylactic reasons. Each patient was kept in bed with their leg elevated until the acute swelling was resolved. Prescription support stockings were ordered to be used during ambulation.

All patients, except three, were examined in the vascular laboratory for evidence of leg swelling or other symptoms and signs of chronic venous insufficiency. They also had

late (more than six months) color venous duplex ultrasound of the lower extremity to check for DVT resolution.

Results

There were 21,943 deliveries during this six-year period at Charleston Area Medical Center. Nineteen patients were diagnosed as having DVT of the lower extremity with or without a pulmonary embolism during their pregnancies. Fourteen of these were diagnosed in the third trimester, four in the second trimester, and one in the first trimester. The clinical diagnosis of DVT was confirmed in each case by a duplex ultrasound (15 patients), and/or phlebography (4 patients).

There were 12 patients in the conventional group. Two of these were given full-dose heparin for 24 hours and, because of complications (one bleeding and one pulmonary embolism), were converted to a lower-dose heparin regimen.

Nine patients were in the non-conventional therapy group. The mean age was 25 years (range 19-38). Follow-up ranged from 6 months to 72 months, with a mean of 29.5 months. Both groups were comparable regarding age and risk factors for DVT. Thirteen of 19 cases were in the lower left extremity. The location of venous thrombosis was iliofemoral in 10 patients, femoral in six patients, hypogastric in two patients, and popliteal in one. Thirteen patients had their protein C and S and antithrombin III levels estimated and 10 patients had lupus anticoagulant studies. In addition, two patients had a protein C deficiency and two had a protein S deficiency.

Eight patients in the non-conventional therapy group had Greenfield filters inserted; one for pulmonary embolism and one for bleeding. Both complications occurred during full-dose intravenous continuous heparin for 24 hours (after filter insertion, heparin was changed to a subcutaneous low-dose regimen); two for free floating iliofemoral DVT; and four for pulmonary embolism prevention in patients with iliofemoral DVT. The filter was inserted via the right internal jugular vein by cutdown in four patients and percutaneously in four others.

In the conventional therapy group, there were three immediate major events -- two pulmonary embolisms, one of which was fatal, and one case of significant retroperitoneal bleeding which necessitated a blood transfusion -- (3/12 = 25%). None of these events occurred in the non-conventional therapy group (0/9, Fisher's exact two-tailed test p = 0.165).

In long-term follow-up, three of the seven patients in the conventional therapy group (43%) had significant leg swelling with partial resolution of the DVT in one and venous occlusion in two by duplex ultrasound. This is in contrast to 3/9 (33%) in the non-conventional group in which two patients had partial resolution and one suffered a venous occlusion (Fisher's exact two-tailed text p = 0.549). Three patients in the conventional therapy group did not have long-term follow-up because there was one death secondary to massive pulmonary embolism, post-delivery; and two patients refused follow-up -- one with hypogastric DVT and pulmonary embolism and one with iliofemoral DVT. There were no complications related to the insertion of the Greenfield filter in the non-conventional therapy group patients, and there was no fetal morbidity or mortality in either group.

Comments

The use of heparin during pregnancy demands an individualized, well-planned regimen with careful control. The two generally accepted treatments include: conventional full-dose heparin anticoagulation before delivery, withdrawal of heparin during delivery, and reinstatement after delivery; and heparin before and after delivery with insertion of an inferior vena cava filter prepartum (8).

In a comprehensive review of heparin therapy for treatment of DVT in pregnancy, Hall (5) noted that only two-thirds of pregnancies in women treated with heparin resulted in normal births; and this figure did not differ from those treated with Coumadin. The heparin-associated abnormalities included stillbirths, spontaneous abortions, and a high incidence of prematurity. This report has been criticized by Weiner (10), who noted that pregnancy loss in the Warfarin group in this study was usually related to placental abruption, fetal anomalies, or fetal/neonatal intracranial hemorrhage -- all Warfarin related. In contrast, pregnancy loss in the heparin group was predominantly secondary to pre-term delivery. However, this alarming report by Hall cannot be ignored.

The rationale of heparin therapy is to prevent further thrombosis and pulmonary embolization and to possibly minimize the effects of post-thrombotic changes in the lower extremity. Heparin anticoagulation has been somewhat effective in achieving the former, but ineffective in preventing valvular damage, and, as a consequence, avoiding the post-phlebitic syndrome. The incidence of such long-term complications can be as high as 90% (11,12). Similar findings were reported by Comerota (13), who found that after 227 patients underwent heparin therapy, significant lysis of thrombi occurred in the legs in only 6% of the patients and partial lysis in an additional 12% of the patients. The remaining 82% of the patients showed no improvement, and there was an actual extension of the degree of thrombosis as visualized in the pre-treatment phlebogram.

The primary risk of heparin is bleeding, which probably occurs in approximately 5% to 10% of patients, but may affect as many as one-third of patients (2,14). Based on these concerns and the fact that two pregnant patients at CAMC within a one-year period had a major complication while on heparin (one with significant retroperitoneal bleeding and one with pulmonary embolus), other alternatives of therapy were explored. To achieve the objective of the goal of therapy for DVT, i.e. the prevention of pulmonary embolism and minimizing the long-term sequelae of post-phlebitic changes, we began the protocol of inserting a Greenfield filter for the prevention of pulmonary embolism in patients with iliofemoral DVT who were at high risk for this complication, and a lower dose of heparin to prevent further thrombotic processes and as prophylaxis for DVT during the course of pregnancy or after labor. There were no complications related to the insertion of a Greenfield filter in this group in our series.

The introduction of the percutaneous titanium Greenfield filter has made its use less invasive and more attractive. Fluoroscopy in general needs to be used briefly when the filter is placed. It has been estimated that two minutes of fluoroscopy to the abdomen exposes the area to 0.5 rad of irradiation, which is within the safe limits, and none of our patients needed more than two minutes of fluoroscopy.

The indications for caval interruption in the treatment of DVT during pregnancy are similar to the

indications in a non-pregnant state. These include complications of heparin therapy (hemorrhage and thrombocytopenia), contraindications to the use of anticoagulation, or pulmonary embolization despite adequate anticoagulation. Successful outcomes using Greenfield filters have been reported in several cases (8,9,15). We propose another indication, primarily for prevention of pulmonary embolism in patients with iliofemoral DVT, which carries a high risk of embolization, in combination with lower-dose heparin, for the possibility of preventing further thrombosis.

The efficacy of low-dose subcutaneous heparin prophylaxis in reducing the incidence of proximal venous thrombosis and fatal pulmonary embolism in general surgical patients has been confirmed by a large number of controlled studies as demonstrated recently by Clagett (16). The incidence of DVT was reduced from 19.1% in controls to 6% in patients receiving low-dose subcutaneous heparin. Pooled data from 24 randomized clinical trials were similarly analyzed to document a 0.2% incidence of fatal pulmonary embolism in patients receiving low-dose heparin versus a 0.7% incidence in controls ($p < 0.001$). The efficacy of low-dose subcutaneous heparin in the treatment of DVT in pregnancy as suggested by our study has not been tested; however, since full-dose heparin did not achieve significant resolution of DVT based on several studies, low-dose heparin may be an alternative for pregnant patients. This is particularly applicable if these patients are protected by a Greenfield filter for the prevention of pulmonary embolism.

Pregnant patients with thrombus confined to the calf can be treated with elastic stockings and ambulation (17). One patient in the non-conventional group in our series was treated in this manner, but she was also followed with serial duplex ultrasound to detect further progression of her DVT.

In conclusion, patients who received low-dose subcutaneous heparin and Greenfield filter insertion in our series tended to do better than those who received full-dose continuous IV heparin treatment. However, since the number of patients in this study is small, further verification is needed.

References

1. Mogensen K, Skibsted L, Wadt J, Nissen F. Thrombectomy of acute iliofemoral venous thrombosis during pregnancy. Surg Gynecol Obstet 1989;169:50-4.
2. Rutherford SE, Phelan JP. Thromboembolic disease in pregnancy. Clin Perinatol 1988; 13(4):719-39.
3. Hirsh J, Cade JF, Gallus AS. Anticoagulation in pregnancy: a review of indications and complications. Am Heart J 1972;83:301-5.
4. Fell G, Strandness DJ Jr. Diagnosis and management of acute venous thrombosis. Clin Obstet Gynecol 1981;24:761-72.
5. Hall JG, Pauli RM, Wilson KM. Maternal and fetal sequelae of anticoagulation during pregnancy. Am J of Medicine 1980;68:122-40.
6. Silverstein A. Neurological complications of anticoagulation therapy. A neurologist's review. Arch Intern Med 1979;139:217-20.
7. Ueland K, McAnulty JH, Ueland FR, Metcalfe J. Special considerations in the use of cardiovascular drugs. Clin Obstet Gynecol 1981;24:809-23.
8. Teodorescu V, Schanzer H. Management of thrombophlebitis in the prepartum period. J Cardiovasc Surg 1992;33:448-50.
9. Rosenfeld JC, Estrada FP, Orr RM. Management of deep venous thrombosis in the pregnant female. J Cardiovasc Surg 1990; 31:678-82.
10. Weiner CP. Diagnosis and management of thromboembolic disease during pregnancy. Clin Obstet Gynecol 1985;28:107-18.
11. Kakkar VV, Lawrence D. Hemodynamic and clinical assessment after therapy for acute deep vein thrombosis. Am J Surg 1985; 150:54-63.
12. Berni GA, Bandyk DF, Zierler RE, et al. Streptokinase treatment of acute arterial occlusion. Ann Surg 1983;198:185-91.
13. Comerota AJ. In: Thrombolytic therapy. New York: Grune and Stratton, 1988:76-7.
14. Holm HA, Abildgaard U, Kalvenes S. Heparin assays and bleeding complications in treatment of deep venous thrombosis with particular reference to retroperitoneal bleeding. Thromb Haemost 1985;53:278-81.
15. Tawes RL Jr., Kennedy PA, Harris EJ, et al. Management of deep venous thrombosis and pulmonary embolism during pregnancy. Am J Surg 1982;144:141-45.
16. Clagett GP, Reisch JS. Prevention of venous thromboembolism in general surgical patients. Ann Surg 1988;208:227-40.
17. Wessler S. The issue of hypercoagulability. In: Kakkar VV, Joular AJ, editors. Thromboembolism; diagnosis and treatment. London: Churchill Livingstone, 1972:13-23.

Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Medical Grand Rounds

Robert C. Byrd Health Sciences Center of WVU
Edited by Irma H. Ullrich, M.D., Professor of Medicine, Section of Endocrinology and Metabolism

Breast cancer - A medical disease?

DISCUSSANT:
EDWARD B. CROWELL JR. M.D., F.A.C.P.
Associate Professor of Medicine, Section of Hematology/Oncology, Mary Babb Randolph Cancer Center

Abstract

The treatment of breast cancer has changed significantly over the last 20 years. It is now believed that breast cancer usually spreads early and that removal of neither lymph nodes nor the breast prolongs survival, although these procedures do improve local control of the disease. Involvement of lymph nodes is prognostically important as a reflection of the body's defenses against spreading cancer cells. Systemic adjuvant therapy with tamoxifen improves survival in estrogen receptor (ER)-positive women and chemotherapy does so in ER-positive or negative women. This article gives an overview of the evolution in the treatment of breast cancer over the past 20 years, and describes the Breast Cancer Prvention Trial (BCPT) and several trials of adjuvant therapy which are now being conducted by the National Surgical Adjuvant Breast Project (NSABP).

Introduction

It is estimated that one out of every nine women will develop breast cancer during her lifetime. There were 181,000 new cases of breast cancer and 46,300 deaths from this disease in the United States in 1992. This represents 32% of all new cancers and 19% of cancer deaths in women. Although the incidence increases sharply with age, breast cancer needs to be a concern for younger women as well since breast cancer is the leading cause of death from disease in women ages 25-34, and the leading single cause of death in those ages 35-54 (1).

There are three general ways in which physicians can approach the problem of breast cancer. The first is to find better ways to treat, and possibly cure, patients who have developed the disease. The second approach is to carry out screening programs to increase cure rates by treating the disease at an early stage. The other method is to conduct programs to examine the possibility of preventing breast cancer.

This article is designed to provide a perspective of the treatment of breast cancer over the past 20 years and discuss the reasons for thinking of breast cancer more as a medical than a surgical disease.

Treatment in the 1970s

The treatment of breast cancer has undergone a dramatic change in the last two decades.

In the 1970s, a woman with a lump in her breast would usually be referred to a surgeon, and, if cancer was found at biopsy, she would have a radical mastectomy, often during the same operation, leaving her with a swollen arm and deformed chest wall. If she developed a recurrence and was premenopausal, the surgeon might do an oophorectomy. If there was a good response but later metastases occurred, she might have an adrenalectomy or even a hypophysectomy. Chemotherapy was still in its infancy and breast cancer was very much a surgeon's disease from beginning to end.

Now, in the 1990s, the treatment of breast cancer has advanced significantly. The surgeon may now only do a lumpectomy with a limited dissection of the axillary nodes and send the patient to the radiotherapist and oncologist for adjuvant therapy. If she has an estrogen receptor (ER) positive tumor and relapses, she may be given tamoxifen instead of an oophorectomy and may later receive aminoglutethimide instead of adrenalectomy. In addition, there are a now a number of effective chemotherapeutic agents available for both adjuvant therapy and management of metastatic disease, so breast cancer management now involves much more medical than surgical treatment.

Breast cancer paradigms

The changes that have occurred since the 1970s in the way the medical profession cares for breast cancer patients can be considered a shift from the Halsteadian paradigm of a hundred years ago to the one today.

In the late 1800s, Halstead devised the radical mastectomy which became the standard of treatment until 1979 when an NIH Consensus Conference proposed that a total mastectomy and axillary dissection would be just as adequate (2). This was not just a change in surgical technique, but represented a basic difference in philosophy about the nature of breast cancer, though not everyone recognized it at the time. The philosophy, or paradigm, behind the Halstead mastectomy was that breast cancer spread in an orderly fashion through the regional lymph nodes before it metastasized. Thus, extensive node dissection might be able to "catch the disease before it spread."

The current paradigm considers breast cancer a systemic disease at the time of diagnosis. Metastases may occur early through the blood stream as well as the nodes, and the regional nodes do not present a barrier to spread. It is known that involvement of the regional nodes is an important prognostic factor in breast cancer, but in the new paradigm this is because it reflects the body's ability (or lack of it) to destroy cancer cells rather than reflecting the amount of tumor spread

Table 1. Risk of recurrence of breast cancer according to lymph node involvement

Number of positive nodes	Recurrence at 10 years (%)
0	30-35
1-3	55-65
4+	80-90

Table 2. Prognostic factors used in deciding adjuvant therapy for breast cancer

1. Age/menopausal status
2. Involvement of axillary nodes
3. Estrogen/Progesterone receptor status
4. Tumor size

(3). Radical surgery does not, therefore, increase the chances of cure as adjuvant chemotherapy or hormonal therapy may.

Surgical trials

A comparison was made of patients treated at the Johns Hopkins Hospital by radical mastectomy between 1889 and 1931 with patients followed without therapy in the Middlesex Hospital in England between 1805 and 1933. The median survival of the operated patients was 3.0 years compared to 2.7 years for the untreated patients indicating that this extensive surgery had no significant effect on survival (4). An incidental observation was that some of the untreated patients survived 20 years. This reflects both the wide heterogeneity of this disease and the fact that breast cancer can be one of the slowest growing human tumors, making it difficult for therapeutic trials to show differences in survival.

The definitive study of radical mastectomy versus lesser operations was B-04 done by the National Surgical Adjuvant Breast and Bowel Project (NSABP) in the 1970s (5). In B-04, patients were randomized into three groups -- radical mastectomy, total mastectomy without axillary node removal followed by radiation, and total mastectomy alone. Axillary nodes were removed in the latter two groups only if they were palpable. No adjuvant therapy was given at that time.

This well-designed study was done not just to compare radical mastectomy to a lesser operation, but to investigate the effect of lymph node resection on survival rates. Forty percent of patients with radical mastectomies had positive axillary nodes, and so it was expected that 40% of the other two groups should have had positive nodes also which were unremoved. Under the Halstead paradigm, these would be expected to be the source of metastases resulting in shorter survival. This was not the case since survival was found to be independent of node resection. However, there was a benefit from node resection, and from radiation, in reducing local tumor recurrence.

The fact that removing the axillary nodes did not affect survival should not be interpreted to mean that axillary nodes are unimportant. As previously mentioned and shown in Table 1, the involvement and degree of involvement of the axillary nodes is one of the strongest predictors of survival in patients with breast cancer because it indicates how well the bodily defenses are able to deal with the patient's cancer (6). This is because patients who deal well with it destroy the cells that reach their lymph nodes, whereas in others, the cancer cells are able to grow in the nodes. The nodes are prognostically valuable because they indicate whether or not a patient was able to destroy cells that had reached other parts of the body as well (3).

After determining that radical mastectomy did not improve survival, the NSABP began a study called B-06 to determine the relative value of lumpectomy, with or without irradiation, to total mastectomy (7). This study revealed that removal of the breast did not affect the patient's survival.

All women in this study had axillary node dissection, but not as extensively as in a radical mastectomy. This was for prognostic purposes and to determine who should receive adjuvant therapy. There was no difference in distant-disease-free survival between the groups, but patients with breast irradiation had fewer recurrences in the breast than did non-irradiated patients. Total mastectomy patients, of course, had none, having lost the breast.

It is important to note that distant-disease-free survival was not affected by having a local breast recurrence. The fact that leaving tumor cells in the breast, or in the nodes, does not affect survival (which mainly reflects metastatic disease), supports the concept that metastasis is an early event and survival is a function of the body's ability to handle those metastases. Residual tumor as a source of new metastases does not seem to be a significant problem. It should be noted that a local chest wall recurrence after total mastectomy has a different significance than local recurrence after a lumpectomy. It may represent a metastasis.

Systemic therapy

If most tumors have spread early in the disease, then early systemic therapy (adjuvant therapy) is needed to ultimately control most breast cancer. The two types of systemic therapy useful in breast cancer are hormonal therapy and chemotherapy.

Benefit from adjuvant chemotherapy was first demonstrated in premenopausal women with positive nodes (8). In the last few years, it has also been shown that adjuvant chemotherapy can improve disease-free survival in both pre- and postmenopausal women with negative axillary nodes (9,10). Overall differences in survival are expected but are slower to appear.

Before the turn of the century, it was shown that oophorectomy could produce regression of metastatic breast cancer, and for a long time hormonal therapy in this disease consisted of ablative surgery (4). About 20 years ago, the anitestrogen tamoxifen was brought into clinical use and found to be as effective as oophorectomy in metastatic disease.

In view of this, tamoxifen was then tried in the adjuvant setting. The NSABP study B-14 was designed to compare tamoxifen to placebo in axillary node-negative ER-positive women. Tamoxifen improved disease-free survival in that study, and recently a statistically significant improvement in overall survival has also been shown for the tamoxifen treated group. This effect was seen in both pre- and postmenopausal women (11).

Current research

Both chemotherapy and hormonal therapy can improve survival in the adjuvant setting but the question remains as to who should receive which adjuvant therapy?

Table 2 shows several major prognostic factors that are used to determine whether and what kind of adjuvant therapy should be used.

Table 3. Gail Model variables used to provide composite risk assessment

1. Number of first-degree relatives with breast cancer
2. Nulliparity or age at first live birth
3. Number of benign breast biopsies
4. Atypical hyperplasia
5. Age at menarche

There are many other factors which have been shown to have prognostic value, but their role in making adjuvant therapy decisions has not yet been demonstrated. Currently, the NSABP has several protocols which address important issues in adjuvant therapy (1).

B-20 is a three-armed protocol in which patients with ER-positive tumors and negative axillary nodes are randomized to tamoxifen alone versus two different chemotherapy regimens, each given with tamoxifen. This will evaluate whether chemotherapy adds any benefit to tamoxifen for patients with such good prognoses.

In B-21, patients with negative nodes and tumors less than one centimeter in size (with unknown ER status because of the small tumor), and who have had lumpectomies, are randomized to receive breast radiation, tamoxifen or both. The question examined here is whether tamoxifen provides adequate control of local recurrences as well as reducing distant metastases.

In B-23, patients with negative nodes who have ER-negative tumors (and who thus have a worse prognosis) are randomized between a shorter, more intensive chemotherapy regimen and a standard regimen each with or without tamoxifen. Tamoxifen has other antitumor effects *in vitro* besides its antiestrogenic activity and its possible role in ER-negative patients is being investigated in this study.

So, there are now two separate purposes in treating breast cancer -- one is to control local disease with surgery and radiation therapy, and the other is to improve survival by controlling metastases with adjuvant therapy. Can we accomplish both aims with one therapy?

Protocol B-18 investigates the usefulness of giving chemotherapy before surgery. This approach has improved survival in a mouse model (12). The results are awaited, but, if preoperative chemotherapy is superior, the next step might be to see if surgery can be eliminated altogether except for the biopsy.

The Prevention Trial

The ultimate advance, of course, would be to prevent breast cancer through a prevention regimen. Currently, the Breast Cancer Prevention Trial (BCPT) is underway at WVU through the NSABP. The rationale for this study was taken from B-14, in which it was found that there were fewer new cancers occurring in the opposite breast in the group treated with tamoxifen compared to the placebo group (11).

Similar results were found in several other adjuvant trials in which tamoxifen was compared to a placebo (13). Thus, it was considered reasonable to use tamoxifen to try to prevent breast cancer in women at high risk for developing this disease. The BCPT trial recruits participants who are at high risk for breast cancer and randomizes them in a double-blind fashion between tamoxifen and the placebo for five years.

In addition to preventing breast cancer, other objectives of the trial are to see if mortality from cardiovascular disease and bone fractures from osteoporosis may be reduced. These latter benefits are projected based on the fact that tamoxifen has a mild estrogenic effect in some areas, e.g. in bone and lipid metabolism, as well as an antiestrogenic effect on the breast (14,15). Results from the Scottish Adjuvant Tamoxifen Trial have also shown a statistically significant reduction in acute myocardial infarction in the group treated with tamoxifen compared to the placebo group of women (16).

Since the BCPT enrolls participants who are not necessarily patients, they must be selected to have a high enough risk of breast cancer to balance any possible risks of taking tamoxifen. The risks include increases in endometrial cancer and thromboembolism which are probably similar to those resulting from the use of estrogen replacement therapy (17).

Factors that are used in the Gail model to predict breast cancer risk are shown in Table 3 (18). Being over 60 years of age is alone a sufficient risk factor to make one eligible for the trial since the risk of breast cancer increases sharply with age. For women between 35 and 60, various combinations of the factors shown in Table 3 may make them eligible including having lobular carcinoma *in situ*.

The goal of the BCPT is to enter 18,000 participants during a two-year accrual period and to follow them for five years on the medication. A computerized risk assessment is done free at WVU for any woman who is interested in the trial. Women in West Virginia or adjoining areas may call 293-3515 in Morgantown or 348-4337 in Charleston for more information and for a risk assessment.

Summary

In summary, the concept that breast cancer often spreads early in its history, together with the availability of newer hormonal and chemotherapeutic agents, has challenged physicians to improve survival more with medical treatment and away from extensive surgical procedures. Tamoxifen is playing a larger role in the management of this disease and is currently being evaluated as a way to prevent the disease in high-risk women.

References

1. Holland JF, Frei E III, Bast RC Jr, et al. Cancer Medicine. 3rd ed. Philadelphia: Lea & Febiger, 1993:1706-74.
2. Special report: Treatment of primary breast cancer. N Engl J Med 1979;301:340.
3. Fisher B. Laboratory and clinical research in breast cancer - a personal adventure: the David A. Karnofsky Memorial Lecture. Can Res 1980;40:3863-74.
4. Henderson IC, Canellos GP. Cancer of the breast: the past decade (first of two parts). N Engl J Med 1980;302:17-30.
5. Fisher B, Redmond C, Fisher ER, et al. Ten-year results of a randomized clinical trial comparing radical mastectomy and total mastectomy with or without radiation. N Engl J Med 1985;312:674-81.
6. Fisher B, Slack N. Number of lymph nodes examined and the prognosis of breast cancer. Surg Gynecol Obstet 1970;131:79-88.
7. Fisher B, Redmond C, Poisson R, et al. Eight-year results of a randomized clinical trial comparing total mastectomy and lumpectomy with or without irradiation in the treatment of breast cancer. N Engl J Med 1989;320:822-8.
8. Fisher B, Ravdin RG, Ausman RK, et al. Surgical adjuvant chemotherapy in cancer of the breast: results of a decade of cooperative investigation. Ann Surg 1968;168:337-56.
9. Fisher B, Redmond C. Systemic therapy in node-negative patients: updated findings from NSABP clinical trials. Monogr Natl Cancer Inst 1992;11:105-16.
10. Prolonged disease-free survival after one course of perioperative adjuvant chemotherapy for node-negative breast cancer. The Ludwig Breast Cancer Study Group. N Engl J Med 1989;320:491-6.
11. Fisher B, Constantino J, Redmond C, et al. A randomized clinical trial evaluating tamoxifen in the treatment of patients with node-negative breast cancer who have estrogen-receptor positive tumors. N Engl J Med 1989;320:479-84.

12. Fisher B, Gunduz N, Saffer EA. Influence of the interval between primary tumor removal and chemotherapy on kinetics and growth of metastases. Can Res 1983;43:1488-92.
13. Nayfield SG, Karp JE, Ford LG, et al. Potential role of tamoxifen in prevention of breast cancer. J Natl Cancer Inst 1991; 83:1450-9.
14. Fornander T, Rutqvist LE, Sjoberg HE, et al. Long-term adjuvant tamoxifen in early breast cancer; effect on bone mineral density in postmenopausal women. J Clin Oncol 1990;8:1019-24.
15. Love RR, Newcomb PA, Wiebe D, et al. Effects of tamoxifen therapy on lipid and lipoprotein levels in postmenopausal patients with node-negative breast cancer. J Natl Cancer Inst 1990;82:1327-32.
16. McDonald CG, Stewart HJ. Fatal myocardial infarction in the Scottish adjuvant tamoxifen trial. Br Med J 1991;303:435-7.
17. Henderson BE, Ross RK, Pike MC. Hormonal chemoprevention of cancer in women. Science 1993;259:633-8.
18. Gail MH, Brinton LA, Byar DP, et al. Projecting individualized probabilities of developing breast cancer for white females who are being examined annually. J Natl Cancer Inst 1989;81:1879-86.

Ed's MED
Medical Waste Systems

We specialize in the legal transportation and disposal of infectious waste.

With our medical disposal service, you can expect:

* **on site consulting**
* **a complete line of packing supplies**
* **outside storage containers**
* **trained, courteous employees**

Service is our priority.

Ed's MED - P.O.Box 6324 Charleston, WV 25362 - (304) 342-4867 - (800) 345-4660

NATIONWIDE INSURANCE
Nationwide is on your side

Congratulations! The Nationwide Medicare Operation wishes to congratulate the providers listed below and on the following page for billing 90 percent of their Medicare claims electronically. These providers will be individually recognized for their commitment to cost containment and improved quality processing as they move into the 21st century. The names are listed in descending order from 100% to 90%. We apologize in advance if any names were inadvertently omitted or misspelled.

Burt E. Schear, M.D. Associates
West Virginia Department of Human Services
Northern Hills Radiology Inc.
E.N.T. Associates of Cincinnati Inc.
Salem Radiologists Inc.
Lima Memorial Hospital
Bethesda Hospital North
Clinical Health Laboratory
Timken Mercy Hospital
Sycamore Professional Associates Inc.
Anthony G. Sola, M.D.
Stouder Memorial Hospital
Aspiration Biopsy Laboratory
Southwest Family Physicians Inc.
Natwarlal M. Jethva, M.D.
Holiday Medical Supply
Fairmont General Hospital
Medical Associates Zanesville
Davis Memorial Hospital
Saint John Medical Center
Lima Group Family Physicians
Pleasant Valley Hospital
Cincinnati Fire Division Paramedics
Kong T. Oh M.D. Inc.
Comp Med Inc.
Lake Emergency Service Inc.
South Dayton Family Physicians Inc.
Lakeshore Radiology Company
Fremont Eye Center, Inc.
Physicians Internal Medicine
Charleston Area Medical Center
Citywide Ambulance Service
Saint Rita's Hospital
Emergency Professional Service Inc.
Kanawha Valley Radiologists
Physicians Cardiovascular Tracing Inc.
Clinitec Laboratory
Kenneth G. Amend, M.D. Inc.
Parma Community Emergency Group
Riverside Hospital
Aultman Pathology Associates Inc.
Norwalk Clinic
Cleveland Physicians Inc.
Gem City Urologists Inc.
Community Health Care Inc.
Physicians Inc.
Mueller and Jennings, M.D. Inc.
Lakewood Medical Associates
Professional Emergency Service
Diversified Physicians Inc.
Rosemar Medical Associates Inc.
Lakeland Emergency Associates Inc.
Clinton Radiology
Cabell Huntington Hospital
Weirton Radiologic Associates
Dunbar Medical Associates
Fairfield Medical Group
Richard W. Watts, M.D. Inc.
Louisville Medical Center Physicians Inc.
Steuben Radiology Associates
Roentgen Diagnostics Inc.
Midwest Medical Consortium Inc.
Atul S. Goswami, M.D.
Anesthesiology Cleveland Clinic
Mansfield Internists Inc.
Clarksburg Radiology Group
Pathmark Inc.
Weirton Medical Center
Nabil F. Alloush, M.D.
Alliance Medical Specialists Inc.
Samaritan Emergency Corporation
Lakeland Eye Surgeons and Consultants Inc.
Associated Emergency Physicians Inc.
Doctors Clinical Laboratory
Cleveland Skin Pathology
Mahoning Valley Emergency Specialists
Cardiologists of Clark and Champaign Counties
Chillicothe Radiology Inc.
Joseph Mersol, M.D. Inc.
Associated Radiologist
Ray A. Brinker, M.D. and Associates
Summit Medical and Cardiovascular Associates
Medical Eye Associates Inc.
Queen City Radiologists Inc.
East Holmes Family Care Inc.
University Suburban Health Laboratory
Middletown Specialty Care
Eye Care Associates Inc.
Huntington Eye Associates Inc.
Kunesh Eye Center Inc.
Erwin A. Maseelall, M.D. Inc.
Monongalia General Hospital
Pathology Associates of Northeast Ohio
First Medical Associates
Vandalia Medical Center Inc.
Canton Aultman Emergency Physicians
Stark County Eye Clinic
Endocrinology Cleveland Clinic
CDC Physicians
Cleveland Foot Clinic
Medical Service Associates of Xenia
Mount Auburn Internists Inc.
Northeast Ohio Pulmonary Associates
Pulmonary Disease Cleveland Clinic
Akron Heart Institute
Valley Radiologists Inc.
Associates in Dermatology
Medina Radiology Group Inc.
Emergency Services Inc.
Marshall Family Practice
Olentangy Emergency Physicians
Shoemakers Ambulance Network
Laboratory Medicine Cleveland Clinic
University Suburban Health Center
Columbus Radiology Corporation
Cardiology Associates of Cincinnati
Marietta Internal Medicine Inc.
Stark Medical Specialists
Trumbull Radiologists
Ashland Internal Medicine
Hypertension Nephrology
Radiological Consultants Stonewall Jackson Memorial Hospital

Urological Associates Springfield
Radiology Consultants Inc.
Riverside Methodist Hospital Pathology Associates Inc.
Camden Clark Memorial Hospital
Raleigh Radiology Inc.
Sass Friedman and Associates Inc.
Minardi Eye Center Inc.
Martinsburg Radiology
Aultman Hospital
Mid Ohio Radiology Inc.
Acute Care Services Inc.
Community Radiology Facility
Mid-Ohio Heart Clinic Inc.
Emergency Practice Associates Inc.
Kevin M. Reid, D.O.
Fairview Eye Center
Phillip L. Horowitz, M.D.
Ohio Eye Associates Inc.
Radiology Cleveland Clinic
Canyon Medical Center Inc.
Medical Center Radiology Inc.
Northwest Family Physicians Inc.
Emergency Services of Dayton
Herzig Krall Medical Group Inc.
Home Xray Service Columbus
Medical Emergency
Gem City Emergency Associates
Central Radiology Consultants
Crystal Arthritis Center Inc.
Sachs Ross and Associates
Anesthesia Associates Euclid
Cincinnati Cardiac Consultants
Internal Medicine Cleveland Clinic
Wheeling Hospital Inc.
Immediate Medical Care
Anderson Radiology Associates
T. C. Hobbs Associates
Regency Park Eye Associates
Bryan Medical Group Inc.
Cardiovascular Clinic Inc.
Ophthalmology Associates Northwest Ohio
Digestivecare Inc.
Suburban Medical Laboratory Inc.
Hillcrest Radiology Associates
Springfield Health Care Center
Memorial Imaging Associates Inc.
Parma Radiologic Associates
Dayton Associates Inc. Radiology Inc.
F. E. Yuzon, M.D. Inc.
Columbus Medical Center Inc.
Smith Clinic Inc.
Southeast Radiology Group Inc.
Bayless Pathology Associates
Genito-Urinary Surgeons Inc.
Radiation Therapy Cleveland Clinic
Bashar A. Mubashir, M.D. Inc.
Cleveland Cardiology Consultants
Miamisburg Family Practice Inc.
Ohio Surgical Specialists
Edgepark Surgical Inc.
James L. Moses, M.D. Inc.
Hill Thomas Company
Emergency Professional Service Inc.
Aultman Anesthesia Inc.
Eye Consultants of Huntington Inc.
Bethesda Oak X-Ray Inc.
Kettering Pathology Associates
Hyde Park Eye Physicians Surgery
Marietta N.C. Imaging Inc.
Gastroenterology Cleveland Clinic
Paul D. Ruff, M.D. Inc.
Hamilton Radiology
Miami Valley Cardiovascular Inc.
Mohammad A. Dar, M.D.
Payne, Osgood, Usilton and Pennington
General Surgery Cleveland Clinic
Diethelm Inglis and Billings
Radiologic Consultants
Ophthalmology Cleveland Clinic
Cardiology Inc.
Family Practice Holzer Clinic
P. H. Medical Laboratory
Metrohealth Radiology
Renal Physicians Inc.
Ashtabula Clinic Inc.
H. J. Thomas Memorial Hospital
Northwest Eye Surgery Inc.
Hematology Medical Oncology
Family Practice of Toledo
Ulrich Morris Company
Home Xray Service Dayton
Marymount Hospital
Wayne County Radiology Inc.
Clarksburg Cardiovascular Consultants Inc.
Radiology Service Canton Inc.
Lincoln Park Eye Associates Inc.
Tri County Radiology Inc.
Miami Radiologists Inc.
Northeast Ohio Kidney Group Inc.
Otolaryngology Cleveland Clinic
Compunet Clinical Laboratory
Firelands Radiology Inc.
Family Physicians Associates Inc.
Piqua Radiologists Inc.
Radiology Inc.
Greater Cincinnati Cardiovascular Consultants
Acute Care Specialists Inc.
Springfield Radiology
Middletown Radiology Associates
M. J. Cooney and M. D. Ricaurte, M..D..
Diagnostic Cardiology Associates
Greene Radiologists Inc.
Eye Surgery Center Ohio Inc.
Valley Pathologists Inc.
Greater Cincinnati Gastrology
Toledo Radiological Associates
University Psychiatrists of Cleveland
Princeton Emergency Physician Billing
Pathology Associates Columbus Inc.
Nuray Radiologists Inc.
Oakhill Medical Associates Inc.
Cardiology Specialists
Neurology Cleveland Clinic
Imaging and Radiology
Consulting Radiologists Corporation
Kowriah N. Amirthalingam, M.D.
North Dayton Pathologists
Radiology Associates Inc.
Sandusky Internists Inc.
Lancaster-Fairfield Community Hospital
Columbus Medical Center Laboratory
Archbold Medical Group
South Charleston Cardiology
Medical Specialists Zanesville
General Anesthesia Service Inc.
East Liverpool Radiology Associates Inc.
Radiological Associates
Radiology Inc.
Hira B. Rohela, M.D.
Akron Radiology Inc.
Internal Medicine Consultants
Nuclear Medicine Cleveland
Newark Family Physicians Inc.

President's Page

James L Comerci M.D.

"The plan" means Americans must make tough choices

Can we make the American people more responsible for their health?

How far will they go to encourage lifestyle changes? Tobacco taxes? Alcohol taxes?

Will there be a difference in the paperwork?

Who will choose the doctor and the treatment?

How will we pay for all of this?

These and many more questions come to mind when you think about "the plan." Even though we will have significant differences on many issues, we must still be ready to participate in the process as it goes forward.

President Clinton outlined six primary areas of the plan - - **SECURITY, SIMPLICITY, SAVINGS, CHOICE, RESPONSIBILITY and FUNDING.** The order of these topics may not be significant, however, in the president's presentation of the plan, the funding part was left until last. As with many government programs, this seems to be the case. I hope this was simply a convenient order to list them and not the order in which the program will be addressed. Regardless, the stage is set and we must be ready to act.

The AMA and the WVSMA are much further ahead of the game than it may seem. The AMA proposed Health Access America several years ago and the WVSMA introduced the Basic Health Care for Employees Act in 1992 to the Legislature -- both of which contained many aspects outlined in the Clinton plan. We must now take advantage of this lead and our knowledge in health care delivery.

SECURITY - Will a card be enough to provide everyone with the health care they may need? **WE** know that we must make the tough choices about how much care we can really afford. Will we be able to provide all our technology to everyone regardless of age, health, or chance of survival?

SIMPLICITY - Getting rid of the paperwork nightmare sounds great, but will we get rid of the cause? We must take on the enormous amount of government regulation, as well as strive for serious liability reform and accountability in the insurance industry.

SAVINGS - The plan proposes to save money by having more people pay into it at reasonable rates. This sounds great, but will we be able to convince some that it would be better to spend $60 per month on health insurance instead of cigarettes? Can we successfully get the majority to take wellness seriously? People must become personally responsible for their own health if the plan is to work.

CHOICE - Choice sounds like a great idea until we explore the factors which have been used to make choices in the past. Will the plans choose doctors using finances as the bottom line or will quality be a factor? Another tough choice -- quality first -- cost second.

RESPONSIBILITY - Have you felt recently that most people feel that because you are a doctor that somehow you are totally responsible for the rising cost of health care? Tough choice #5 is to see that consumers, the insurance industry, hospitals, labs, lawyers, pharmaceutical companies, nurses, doctors and others share this responsibility equally.

FUNDING - Why is this last? As I mentioned before, I hope the president did not leave this point until last on purpose. My list of tough choices includes raising the taxes substantially on tobacco and other "sin" products, as well as obtaining some contributions from all those individuals who can afford to pay into the plan. The rest of the money needed to fund the plan should come from the savings obtained from serious liability reform and from utilization based on appropriate care not on cost alone, as well as from controlling other factors that affect the overall cost of health care.

I know that it can be done. I also know that it cannot be done right without **PHYSICIAN** input in the process. Find an opportunity to be a part of the change and see that the tough choices are made.

James L. Comerci, M.D.

Health care disaster

The Clinton health care reform plan promises to be an unmitigated and total disaster for anyone having even the remotest connection with it. That, as a matter of fact, includes everyone in this country since, under the Clinton plan, health care coverage is to be universal and mandatory.

It will certainly be a motivational disaster for doctors who will have every medical decision questioned, second guessed or dictated to them by "managers" with far less education, training, experience and good sense than they, and with no prior or anticipated personal contact with the patient involved or perhaps with any other patient in their careers. Any physician with a sense of pride and dignity who is presently involved with HMO-style care has already found such management degrading and intolerable.

The stock market very clearly reflects the damage any medicine-associated business expects to receive under the reform plan. Many hospitals will close and the 10 plus percent of the work force employed in providing health care, rather than feeling the security promised by the Clintons through their plan, will instead be encompassed by insecurity as they find their jobs in jeopardy.

If there is a taxpayer who actually believes the Clinton plan can be paid for without a massive tax increase, he or she should be advised to stop smoking that funny stuff. Members of the presidential cabinet and Democratic leaders do not believe it. One has suggested a presidential fantasy might account for such a claim.

Responsible journalists who have reviewed the simplified system trumpeted by the president have described it as akin to a rube Goldberg contraption. With a trillion dollars filtering through the system and the spectre of the recent savings and loan debacle staring at Congress and the administration, can anyone imagine the number of counters and checkers needed, the reviewing bodies and committees, the forms, papers, computers, offices, support personnel and on and on that will spring like mushrooms to control this simplified system?

The Department of Agriculture has been held up as a horrible example of bureaucratic overgrowth as it approaches one full-time employee for every farm in this country. Whatever name might grace the new department intended to control Medicine will displace Agriculture in a flash from first place in the bureaucratic horror story list.

By far, the greatest sufferers in the disaster being promoted by the Clintons will be those needing and expecting good medical care. Rationing of care and shortages of capital funds for advancing medical care are in the future for those gulled reform enthusiasts already enjoying their security. From which ones of those happy, content and secure medical care recipients will the $250 billion or so in "wasted" medical care be wrested?

It all makes good economic sense as long as someone else's medical care is being cut back. But, my care? Who is it that will declare that anything spent on his/her care is wasted?

It seems safe to say that never in our legislative history has so important a topic been addressed by such an amorphous proposal. The president has said so much on so many different occasions about his wife's health care reform plan that anyone with any vague notion about improving health care is certain that Hillary harbors those very same desires and has placed them close to her husband's heart.

That warm feeling of security being traded upon by the Clintons might turn out to be as transient as the smell of fresh baked bread as the loaf turns stale. We have a magnificent system of medical care. We are being asked to risk the disaster of the ruin of that system for a sense of security provided by the illusion that someone else will bear the cost. The sales technique is the one used by any con artist.

— SDW

Our Readers Speak

Actual courses ???

Editor's Note: *This was sent to us by Dr. Edward L. Pinney Jr., M.D., of Martinsburg who found it on a street corner in Martinsburg. Dr. Pinney said he did not know "whether it drifted down from a dark cloud or came from a vent in an infernal region. It appears to be a fragment from a course catalog for some kind of curriculum."*

Health Care Reform (Rip Off) Institute

Courses:

Note: Odd numbered courses are given in the first semester and even numbered courses the second semester. Courses numbered 500 and above are graduate courses.

Greed and Exploitation 101 (Political aspects of Healthcare)

Public Greed-Public Debt 301 (Everything for Everybody for Nothing)

Substance Disorders Management 304 (28 day magic, codependency, serenity)

Paranoia 301 (Convincing the patient that everything that happens is someone else's fault)

Blame the Doctor 512 (A graduate course in blaming the helper)

Synonyms 816 (Patients = Consumers, Doctors = Providers and other euphemisms to denigrate the professional aspects of healthcare)

The Healthcare Industry 813 (A really advanced course in extracting profit and power from the fact that our bodies are unreliable and wear out)

Irresponsibility 101 (Really a trivial course)

Quality of care 306 (Finding the cheapest substitute for adequate care that people will believe)

Ways of Attributing Problems to the "Inner Child" 306

More of the same 412

6-26-93

Time to set term limitations

I was interested in reading in the *West Virginia Medical Journal* just how much more money is contributed by the plaintiff lawyers in this state to advance their cause than the physicians in this state.

Do you think this might possibly mean that the lawyers are getting more out of their donations than the physicians? There are those skeptics amongst some of the contributing physicians that they are not getting their moneys worth even for the minuscule amount of money donated.

There are even some skeptics amongst the dues-paying members of the West Virginia State Medical Association who feel that they do not get their moneys worth from their dues. They see the same tired old group mouthing the same tired platitudes and accomplishing little or nothing.

Perhaps it is time to set term limitations on our appointees to various high offices.

James H. Wiley, M.D.
Morgantown

In My Opinion

Why I'm joining the physicians union

I've known about the Union of American Physicians and Dentists for several years, but never considered joining. I read the writings of Dr. Sanford Marcus, their former president, and paid little heed. I consider myself more pro-employer than pro-labor, and I didn't find it relevant to my practice -- until now.

We were told that we could achieve our goals through organized medicine, and we got steamrolled. I've been a member of the AMA for 20 years, I'm an AMA-HMSS delegate, and I'm on the Legislative Committee of the West Virginia State Medical Association as well as secretary-treasurer of the Raleigh County Medical Society, chief of staff at one hospital, chief of staff-elect at another, and all of this hasn't mattered.

While we are being systematically deprived of our livelihood, we debate such issues as gay rights, nuclear-free zones, smoke-free hospitals, condom distribution, and nod approvingly to those who proclaim that shooting doctors who perform abortions is an exalted expression of free speech.

We were told to become politically active, and we elected five delegates to the state Legislature. Our voice was heard, but we were ignored, told to sit down and shut up.

The Sherman Anti-Trust Law was enacted in 1890, and its present enforcement is outdated and destructive of the efforts of physicians. An HMO may speak for millions of patients, or the government for tens of millions, but if two doctors discuss with each other how they should respond, it is a punishable crime, it is collusion, it is prohibited activity. The only exception to anti-trust liability is a labor union. If there are only patients and doctors, no union is needed, but this day is long gone.

The UAPD is 21 years old, has 4,000 members, has weathered the storm of anti-trust investigation, and has represented its member physicians.

Some 70 physicians in Raleigh County have, like me, joined the union. We feel betrayed by our state government, with its class legislation tactics, its bullying, its in-your-face approach to medicine. We see the federal government cooking up radical reform behind closed doors, starting with 500 geniuses, most of whom have never treated a patient. To be effective, we must first recognize who is the enemy. It is not the patient. A patient who is sick and wants to get well is our ally. Rather, it is the paymasters, the "third-party payors," who are better organized, more powerful, and unscrupulous. They include both agencies of government and so-called insurance companies, better labeled "unsurance."

What do I hope to achieve by joining?

In the short term, I hope the UAPD will enter the legal battles against the provider taxes as an amicus. Secondly, I hope to send a message to state government that we will no longer roll over and play dead. In the long term, I hope we'll be able to bargain effectively with the third parties as equals, to say to them "If you do A, I'll do B, and so will my colleagues." Only then can our voice be heard.

We may not succeed, but we fail if we don't try. In the words of Theodore Roosevelt, our place should be with the man who "spends himself in a worthy cause; who at best, knows the triumph of high achievement; and who, at worst, if he fails, at best fails while daring greatly, so that his place shall never be with those cold and timid souls who know neither victory nor defeat."

Wallace D. Johnson, M.D.
Beckley

The AMA Brings Washington to You.

Shape Your Future

at the Physicians' Forum on Health System Reform.

The times and places for open discussions of physicians' concerns

October 22-24 in San Francisco

November 4-6 in Dallas

November 19-21 in Philadelphia

Now is the time for direct dialogue with members of the Administration and Congress. And now, the American Medical Association (AMA) brings you the *Physicians' Forum: Agenda for Action,* an unprecedented opportunity for every physician to interact with policy makers and help shape the way health care will be delivered.

Speak face to face with Congressional leaders, Presidential advisors and top Administration officials on the political pressures that will ultimately form health care policy. Help ensure that patients' needs remain the focus of reform. Hear governors and heads of state health departments describe how their states are preparing for a new national policy.

The Physicians' Forum series of conferences invites all physicians, not just AMA members, to join the dialogue on issues vital to their practices. Physicians, board members and officers of the AMA will come together to reach common ground.

Voice your concerns about the coming changes. Do not wait passively for those changes to be imposed without your input. The *Physicians' Forum* is the time and place to speak out and make an impact.

Your attendence is crucial.
Call toll free 800 621-8335.
Conference fee for meeting facilities and food service—AMA members $50, nonmembers $125. MasterCard, Visa, American Express, Optima are accepted.

American Medical Association
Physicians dedicated to the health of America

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

oppler
-Scan
eal Time

SOUND

Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

At Mid-Winter

Physician/Public Session to focus on health care reform in Oregon, Vermont, West Virginia

"Health System Reform: The States' Views" is the title of the Physician/Public Session which will be conducted on Friday, January 21 at 7 p.m. during the WVSMA's 27th Mid-Winter Clinical Conference, which is set for January 20-23 at the Lakeview Resort and Conference Center in Morgantown.

Presenting their views on health care reform will be **Ralph Crawshaw, M.D.,** a clinical professor of psychiatry at the University of Oregon Medical School; **Dr. Arnold Golodetz,** a clinical associate professor of medicine at the University of Vermont College of Medicine, and **WVSMA President Dr. James Comerci.** Dr. Comerci will also be the moderator for this discussion.

Biographical information about these speakers begins below and additional details about the Mid-Winter Clinical Conference can be obtained by contacting Nancie Divvens at (304) 925-0342. A registration form for the conference will be published in next month's *Journal.*

Crawshaw

Golodetz

Comerci

Panelists highlighted

Dr. Crawshaw is a native of New York City who received his medical degree in 1947 from the New York University College of Medicine. He then served three years in the U.S. Navy Medical Corps before completing postgraduate studies at Lenox Hill Hospital, the Menninger School of Psychiatry and Oregon State Hospital.

In 1954, Dr. Crawshaw went into private practice in Washington, D.C. Later that same year, he accepted a position as a staff psychiatrist at C. F. Menninger Memorial Hospital in Topeka, Kan., where he was promoted to assistant chief of the V.A. Mental Hygiene Clinic in 1957. Dr. Crawshaw held this post for three years and then relocated to Portland, Ore., to open a private practice and join the staff of the Community Child Guidance Clinic, where he worked until 1963. In addition, from 1961-67, Dr. Crawshaw served as the clinic director of the Tualatin Valley Guidance Clinic in Beavertown, Ore., and continued his private practice.

In 1976, Dr. Crawshaw joined the faculty at the University of Oregon Medical School as a clinical professor in the Department of Psychiatry, a post he still holds today in addition to being a clinical professor in the Department of Public Health and Preventive Medicine at the university. Still in private practice, Dr. Crawshaw has also been a trustee of the Oregon Medical Association since 1972.

The recipient of numerous distinguished awards during his career, Dr. Crawshaw's most recent honors have included being named Doctor of the Year by the Multnomah County Medical Society in 1989; receiving the AMA's Benjamin Rush Award for outstanding civic accomplishment in 1990; and being presented with the Pirogov Medal for humanitarian services by the Russian government in 1992. A reviewer for *JAMA,* Dr. Crawshaw is also a contributing editor for *The Pharos - The Journal of the Medical Honor Society, Aerospace Psychology,* and the *Western Journal of Medicine.*

Dr. Golodetz was born in Hamburg, Germany, and received a B.A. degree from Harvard College in 1948, and then obtained his medical degree in 1953 from the University of Rochester. After interning at Peter Bent Brigham Hospital in Boston and serving as a general medical officer in the U.S. Air Force Medical Corps, Dr. Golodetz became the assistant medical resident at Beth Israel Hospital in Boston for two years. From 1958-59, he served as the senior medical resident at the Boston V.A. Hospital.

In 1959, Dr. Golodetz became an instructor at the Tufts University School of Medicine, where he was soon named an associate professor. He remained on the faculty until 1969 and during these years Dr. Golodetz was also an assisting physician at Boston City Hospital and was an attending physician at Boston Veterans Administration Hospital.

Dr. Golodetz relocated to Vermont in 1969 to join the faculty of the University of Vermont College of Medicine as an associate professor of medicine and community medicine. In 1971, he became an associate professor of rehabilitation medicine and medicine and he held this post until 1983, when he assumed his current role as a clinical associate professor of medicine.

Very active in many health care organizations and civic endeavors, Dr.

Golodetz presently serves on the board and is chair of the Community Ethics Committee of the Visiting Nurse Association in Burlington, and is chairman of both the Medical Ethics Committee of the Vermont State Medical Society and the Steering Committee for the Vermont Ethics Network. In addition, Dr. Golodetz is a board member for the Vermont Program for Quality in Health Care and for Project Home.

Dr. Comerci became president of the WVSMA in August. A native of Beckley, Dr. Comerci received both his B.A. degree in chemistry and his doctor of medicine degree from West Virginia University. He completed his residency in family medicine at Wheeling Hospital from 1980-83 and then went into private practice in Wheeling.

A member of the WVSMA since 1984, Dr. Comerci began serving on Council in 1987 and was named vice president in 1991, then president-elect in 1992. In addition to his positions on Council and the Executive Committee, Dr. Comerci served as program chairman of the WVSMA's Annual Meeting in 1990, and has been a member of the Legislative Committee since 1991.

Besides his roles with the WVSMA, Dr. Comerci is also a member of the AMA and the Ohio County Medical Society, of which he was president in 1990. He is board certified by the American Board of Family Practice.

A clinical assistant professor of family medicine at WVU, Dr. Comerci is also very active in the Wheeling area medical community. He is a board member, a volunteer physician and a member of the Prenatal Care Committee at Wheeling Health Right, and is a part-time team physician at Bethany College. In addition, Dr. Comerci serves on the Utilization Review Committee at Good Shepherd Nursing Home.

Fourth Annual Rush Symposium planned for November 3

"Applications of Advancing Technology in Contemporary Hepatology" will be the topic of the Fourth Annual Rush Symposium on Transplantation which will be conducted at Rush-Presbyterian-St. Luke's Medical Center in Chicago on Wednesday, November 3.

Special attention will be focused on innovative techniques offering the successful treatment of various liver diseases and biliary complications after liver transplantation.

For more information, call the Transplant Program Physician Relations Coordinator at (312) 942-6242.

Board of Medicine issues notice on methylphenidate

A rule of the West Virginia Board of Medicine (11 CSR 1A 12.1[ee]) provides that physicians may be disciplined by the Board for prescribing, dispensing, administering, supplying, selling or giving any amphetamine or sympathomimetic amine drug and a compound designated as a Schedule II controlled substance, unless such a drug is for narcolepsy, attention deficit disorder, drug induced brain dysfunction, depression, or clinical investigation when an investigative protocol has been submitted to the Board.

While methylphenidate is a compound designated as a Schedule II controlled substance and a sympathomimetic drug structurally related to amphetamine, methylphenidate is technically neither an amine nor an amphetamine. Therefore, the prescribing of methylphenidate is not restricted under West Virginia Board of Medicine Rule 11 CSR 1A 12.1(ee).

The Board understands that methylphenidate is prescribed by some physicians for the relief of pain and neuropsychiatric symptoms in the terminally ill, and wishes to clarify that physicians need not be concerned about the application of 11 CSR 1A 12.1(ee) to the prescribing of methylphenidate for such patients.

Laser surgery seminar set for October 30

A decade of progress in laser surgery applications will be highlighted during Laser Surgery Seminar X on Saturday, October 30 at the Charleston Marriott.

Topics will cover laser surgery procedures in general surgery, as well as cardiology, urology, dermatology, gynecology, head and neck surgery, facial cosmetic surgery and eye surgery. Faculty represent the Johns Hopkins Medical Institutions, University of Kentucky, University of Pittsburgh School of Medicine, Ohio State University, Western Kentucky Institute of Plastic, Reconstructive and Aesthetic Surgery, as well as the Eye and Ear Clinic of Charleston and the Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown and Charleston Divisions.

Sponsored by The Eye and Ear Clinic of Charleston and the Department of Surgery, the Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division, and the Charleston Area Medical Center, the seminar is open to physicians, physician assistants, nurses, nurse anesthetists and other health professionals. Romeo Y. Lim, M.D., chief of surgery at The Eye and Ear Clinic of Charleston, is seminar director. The seminar provides 4.5 CME units, 4.5 CE units of the AANA, and .45 CEUs.

Further information is available by contacting Mary Jane Willis, PA, program coordinator at 343-4371 or toll-free in West Virginia, 1-800-642-3049, ext. 227.

Charleston site for hospice conference

"Hospice and Palliative Care" is the title of a regional conference which will be held at the University of Charleston on November 9 and 10.

Featured speakers will be Dr. Barry Cole, the former medical director of Hospice of Northern Nevada, and Dr. Porter Storey, medical director of the Hospice at Texas Medical Center.

For more details, phone 768-8523 or toll free 1-800-560-8523.

Annual Williamsburg meeting on heart disease scheduled

The Twenty-First Annual Williamsburg Conference on Heart Disease will be presented by the American College of Cardiology from December 5-8 in Williamsburg, Va. A total of 19 CME credits in the AMA's Category I will be offered to participants.

For further information contact: Registration Secretary, Extramural Programs Dept., American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20814-1699; 800-257-4739 or 301-897-2695 outside the U.S. and Canada.

The Hospital Medical Staff Section
22nd Assembly Meeting
December 2 - 6, 1993
Hyatt Regency
New Orleans

HMSS representatives won't want to miss this year's AMA-HMSS Interim Assembly Meeting. They will have an opportunity to learn about and discuss with AMA's leadership and staff the details of President Clinton's health care reform proposal as well as AMA's legislative strategy.

HMSS representatives will also be presented with an overview of physician and physician/hospital organizations, including the physician hospital organization, management services organizations, the foundation and physician equity models, and the hospital-affiliated professional corporation.

Review and analysis of President Clinton's Health Care Reform Plan

President Clinton released his new health care reform plan in September. HMSS representatives in this session will hear a full review and analysis of the plan.

Physician Organizations & Hospital Organizations

Henry E Golembesky, MD, director of Integrated Health Systems Practice of American Practices Management and former chief executive officer of UniMed America, will discuss and examine, from a physician's perspective, the advantages and disadvantages of the organizational structures being created in response to federal, state, and business health care reform initiatives. He also will identify the key elements of successful physician and physician/hospital organizations.

Dr Golembesky will be joined by several physicians who currently practice in these structures. They will share their experiences and cite the challenges and opportunities for physicians. HMSS representatives will be able to ask questions of the physician panelists and together explore mechanisms to maintain physician control in the credentialing of network providers, the monitoring and assessment of patient care, and the setting of quality of care standards/outcomes.

Don't miss this opportunity to acquire leadership skills to help your physician community succeed!

For information please call
312 464-4745 or 464-4761

Hospital Medical Staff Section

American Medical Association

Physicians dedicated to the health of America

Successful Money Management Seminars

FOR WEST VIRGINIA STATE MEDICAL ASSOCIATION MEMBERS AND THEIR SPOUSES

- Beckley October 27
- Parkersburg November 4, November 11 and November 18

Comprehensive Seminar Agenda

SESSION 1

- Your Foundation for Financial Independence
  - Why Everyone Needs Financial Planning
  - Six Main Objectives of Financial Planning
  - Reallocating Your Income
  - The Success Triangle™
  - Six Main Reasons People Fail Financially
  - Take Advantage of Your Lifetime Earning Power
  - Become Financially Independent;
  - The Eighth Wonder of the World—Compound Interest
  - The Effects of Inflation
  - Your Tax Bracket—How it Affects Your Financial Plan
- Putting Your Dollars to Work—Part I
  - Importance of Cash Reserves
  - Types of Cash Reserves
  - Restricted Cash Reserves
  - Tax-Deferred Fixed Annuities
  - Fixed-Income Securities
    - Government Securities
    - Corporate Bonds
    - Municipal Bonds
- Putting Your Dollars to Work—Part II
  - Equity Investments
    - Common Stock
    - Preferred Stock
    - Reading the Stock Tables
    - Risk Factors
    - Managed Accounts
  - Ten Steps to Financial Success
    - Your Personal Financial Plan—The Key to Your Success

SESSION 2

- Putting Your Dollars to Work—Part II
  - Mutual Funds
    - Families of Funds
    - Types of Funds
    - Dollar Cost Averaging
    - Selecting Specific Funds
    - Asset Allocation
  - Guaranteed Versus Equity Investments
  - Limited Partnerships
  - Tangible Assets
  - College Funding
- Retirement Planning
  - Social Security
- 401(k) Plans
- 403(b) Tax-Sheltered Annuities
- Simplified Employee Pensions (SEP-IRA)
- Individual Retirement Accounts (IRA)

SESSION 3

- Retirement Planning (continued)
  - Tax-Deferred Variable Annuities
  - Systematic Withdrawal Programs
  - Risk Management
  - Insuring Your Most Valuable Asset
  - Long-Term Health Care
  - Life Insurance
  - Enhancing Your Pension Benefits with Life Insurance
  - Estate Planning
    - Objectives of Estate Planning
    - Probate-Should it be avoided?
    - Living Revocable Trusts

SESSION 4

Optional

Everyone attending this seminar is entitled to a personal financial planning consultation after the conclusion of Session Three. This is your opportunity to ask specific personal questions regarding your financial future at no additional cost.

ENROLLMENT FORM

(Member's Name) _____ (Spouse's Name) _____

(Mailing Address) _____

(Telephone Number) _____ (Seminar Location I Plan To Attend) _____

Call (304) 925-0342 for more information.

Registration Fee: $250 (member) $125 (spouse)

Bonus for early registration: If registration is confirmed 10 days prior to the seminar, the spousal fee will be waived.

* Make check payable to West Virginia State Medical Association
* Mail enrollment form and fees to: West Virginia State Medical Association
  P. O. Box 4106
  Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

CAMC/Robert C. Byrd Health Sciences Center of WVU - Charleston

October 27
"Ethical Dilemmas in Pain Management," 8 a.m. - 12:45 p.m.

November 4
"Teleconference on Dermatology Through the Life Span," noon - 1 p.m., HCS and other satellite locations

November 18
"Teleconference on Infertility Work-up and Treatment," noon - 1 p.m., HCS and other satellite locations

Marshall University - Huntington

November 12
"Adolescent Medicine - Who's Responsible?" Cabell Huntington Hospital, PDR6

November 12-14
"7th Annual Family Practice Weekend and Sports Medicine Conference," (sponsored by the WVAAFP, The Family Medicine Foundation of West Virginia, the MU Dept. of Family and Community Health, the MU Division of Sports Medicine, and the MU Sports Science and Wellness Institute), Radisson Hotel, Huntington

Robert C. Byrd Health Sciences Center of WVU - Morgantown

November 5
"Fall Cancer Conference - Healing the Patient With Cancer: The Role of Supportive Care" (sponsored by the WVU Dept. of Medicine and the Mary Babb Randolph Cancer Center)

November 6
"Otolaryngology Update for Primary Care" (sponsored by the WVU Dept. of Otolaryngology)*

November 18-20
"OB/GYN Women's Health Symposium 1993" (sponsored by the WVU Dept. of Obstetrics/ Gynecology)*

November 20
"Senior Care '93" (sponsored by the WVU Geriatric Program)*

**Held in conjunction with a home football game*

West Virginia State Medical Association - Charleston

October 30
"First Generation Loss Control Seminar," Blennerhasset Hotel, Parkersburg

November 13
"Marbury v. Madison Loss Control Program," Marriott Hotel, Charleston

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Fairmont ★ Fairmont Clinic, Nov. 17, 1 p.m., "Dealing with Delirium," Robert Keefover, M.D.

★ Fairmont General Hospital, Nov. 2, 7:30 p.m., "Cystic Fibrosis," Stephen Aronoff, M.D.

New Martinsville ★ Wetzel County Hospital, Nov. 11, 11:30 a.m., "Evaluation and Treatment of Dizziness," Stephen Wetmore, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, Oct. 28, noon, "Breast Cancer," Arvind Kamthan, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Oct. 25, 4 p.m., "Impotence," Stanley Kandzari, M.D.

**To be announced*

ASSOCIATES IN OBSTETRICS AND GYNECOLOGY

OFFERING PERSONALIZED CARE 24 HOURS A DAY 7 DAYS A WEEK
FOR OBSTETRICAL & GYNECOLOGICAL EMERGENCIES & FOR INFANT DELIVERY

OUTPATIENT & OFFICE SURGERY

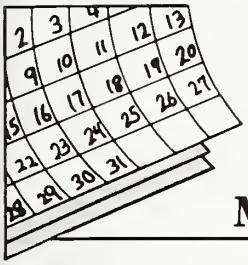
9 MEMBER GROUP OF OB-GYN SPECIALISTS

CHARLES W. MERRITT, M.D. **MICHAEL T. WEBB, M.D.** **NORMAN W. TAYLOR, M.D.**
ROBERT P. PULLIAM, M.D. **ANGEL L. ROSAS, M.D.** **WILLIAM A. SCARING, M.D.**
OWEN C. MEADOWS, M.D. **NANCY R. WEBB, M.D.** **NORMAN L. SIEGEL, M.D.**

- CONTRACEPTIVE COUNSELING
- INFERTILITY EVALUATIONS
- ARTIFICIAL INSEMINATION
- BREAST SCREENING
- UROLOGICAL EVALUATIONS & TREATMENT

255-1541

410 CARRIAGE DR. BECKLEY



Medical Meetings

October

28-31–87th Annual Scientific Assembly of the Southern Medical Association, New Orleans

28-31–Intense Orthopedic and Sports Medicine MRI Weekend Review (sponsored by MRI Education Foundation, Inc.), Cincinnati

November

3–Fourth Annual Rush Symposium on Transplantation, Rush-Presbyterian-St. Luke's Medical Center, Chicago

3-7–American Medical Women's Association, New York City

4-7–12th Annual Scientific Meeting of the American Pain Society, Orlando, Fla.

4-7–139th Annual Meeting of the North Carolina Medical Society, Charlotte

6-7–Dermatology for the Non-Dermatologist (sponsored by Ohio State University), Columbus

7-12–3rd International Conference on Pediatric Otorhinolaryngology of the European Working Group on Pediatric Otorhinolaryngology, Jerusalem, Israel

8-11–American Heart Association, Atlanta

8-11–The Future of Integrated Healthcare Systems (sponsored by The Healthcare Forum and Inova Health System), Reston, Va.

9–Preparing for Electronic Patient Record Systems (sponsored by the Medical Records Institute), Denver

9-10–Regional Hospice and Palliative Care Conference (sponsored by Kanawha Hospice Care, Inc.) Charleston

10-12–11th Chemotherapy Foundation Symposium: Innovative Cancer Chemotherapy for Tomorrow (sponsored by the Division of Medical Oncology and the Post Graduate School of the Mount Sinai School of Medicine), New York City

11-14–40th Annual Meeting of the Academy of Psychosomatic Medicine - Bridging the Gap Between Knowledge and Clinical Practice: The C-L Psychiatrist's Role, New Orleans

12-13–Interdisciplinary Approach to the Diagnosis and Management of Endocrine Disorders (sponsored by George Washington University), Washington, D.C.

13-17–American College of Allergy and Immunology, Atlanta

14-18–97th Meeting of the American Academy of Ophthalmology, Chicago

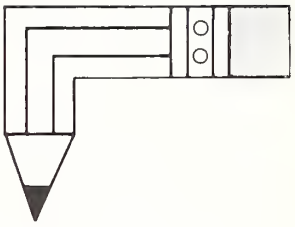
16–American Cancer Society, Atlanta

19-23–Gerontological Society of America, New Orleans

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



On Parting

Although the time has come for us to part,
Let not your mind be sending me away;
Remember always how we got our start.

Keep me in your prayers and in your heart;
But please don't put your sadness on display,
Although the time has come for us to part.

No matter just how long we are apart,
Or that reunion, time may long delay,
Remember always how we got our start.

I find it hard to make myself depart,
And can't find words that now I want to say,
Although the time has come for us to part.

Yet keep me in your thoughts and in your heart,
No matter just how far I am away;
Remember always how we got our start.

A pleasant nature you have made an art,
So let not now your cheerful nature sway,
Although the time has come for us to part;
Remember always how we got our start.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

This page of material is submitted and paid for by the Bureau of Public Health.

Birthday cards carry important message for women turning 40

Since this summer, women in West Virginia have been receiving special birthday cards to mark their 40th birthday. The cards are being sent by staff from the Bureau of Public Health's Office of Maternal and Child Health to remind women of the importance of having a regular mammogram to screen for breast cancer.

Around the first of every month, birthday cards are sent out to women who will turn 40 in that month. Approximately 2,000 cards are sent out each month. The cards present the message, "Give yourself the gift so many want you to have - a mammogram. You're worth it." Recipients are also given the phone number, 1-800-4-CANCER, to call for more information or help in finding mammography services in or near their community.

The project is a part of the Breast and Cervical Cancer Screening Program, funded by the Centers for Disease Control. The purpose of the program is to increase the number of West Virginia women who routinely receive a mammogram and a Pap test. Statistics have shown that when breast and cervical cancer are detected in the early stages of the disease, they are more easily treated and the five-year survival rates are much greater.

There were 1,140 cases of breast cancer detected and reported in West Virginia in 1991, and there were 336 deaths due to breast cancer that year. About 63% of all breast cancer cases were diagnosed in the early stages of the disease in 1991, while some 35% were diagnosed in late disease stages when treatment is less effective.

For more information, call the Breast and Cervical Cancer Screening Program at (304) 558-5388.

Immunization after birth can lower chance of HBV in newborns

West Virginia women who are pregnant or planning to become pregnant should be tested for the Hepatitis B Virus (HBV), since it is possible for a mother to pass the virus on to her baby during the birthing process. However, proper vaccination of the baby immediately after birth could lower the child's risk of HBV infection.

Often, symptoms of HBV may not appear until years after infection, so a woman could unknowingly be carrying the virus and pass it on at birth. However, if she does know she carries HBV, she and her physician can make sure her newborn receives a first dose of the vaccine and the Hepatitis B Immune Globulin within 12 hours after birth, and additional doses of the vaccine one month and six months later. This process can result in an 85% to 95% success rate in preventing the development of Hepatitis B in babies born to infected mothers.

Preventing the transmission of HBV from mother to child is one of the most effective Hepatitis B prevention plans available. Currently, staff from the Immunization Program and the Bureau's Right From The Start project are working together to detect and prevent the transmission of HBV. All maternity patients who receive assistance from public-funded programs, such as Medicaid, are screened for HBV. The Right From The Start staff works with mothers who test positive to educate them about HBV and to ensure that their infants receive all recommended doses of the vaccine, which is provided by the state. Testing is also done when the vaccine series is completed to make sure the baby has developed immunity against HBV.

For more information about Hepatitis B prevention and vaccination, call the Immunization Program at 1-800-642-3634 or (304) 558-2188.

Teleconference to feature AIDS czar

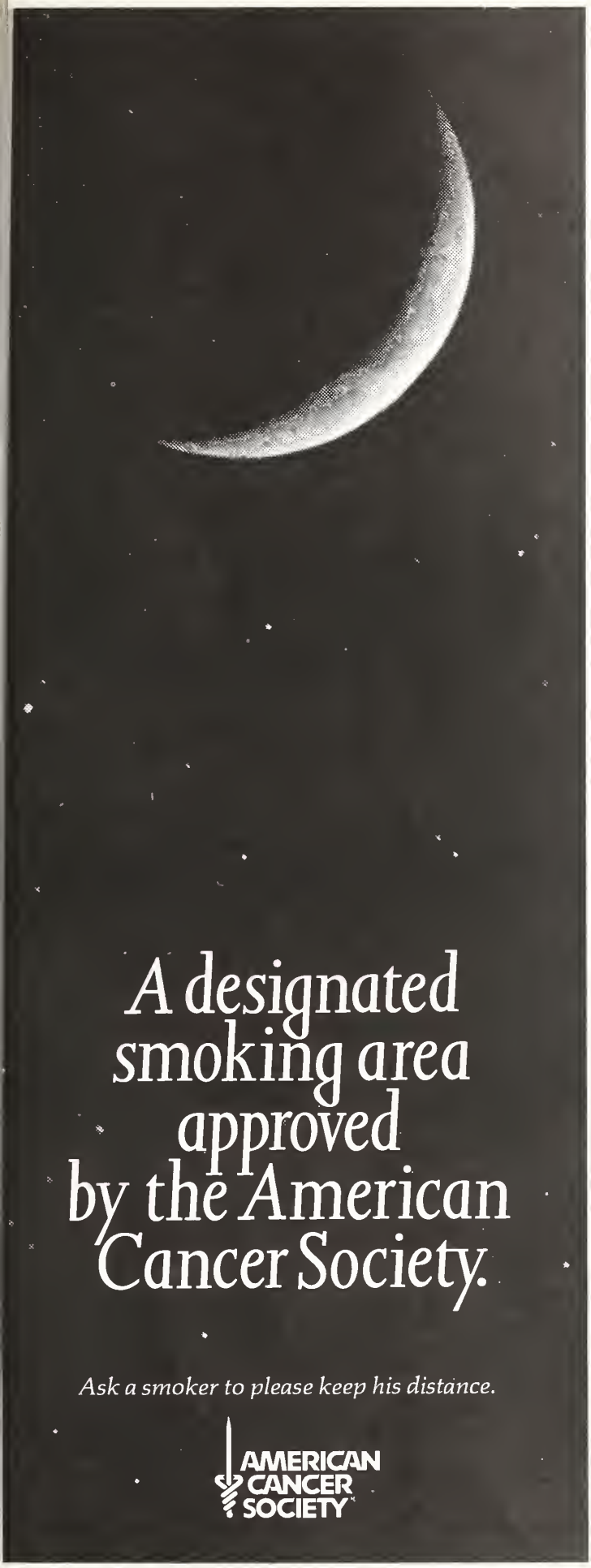
Kristine Gebbie, national AIDS policy coordinator, will be the keynote speaker for a live, interactive teleconference presented by the Bureau of Public Health AIDS Program. She will be speaking on "The Challenge of AIDS/HIV in Rural America."

The teleconference is set for November 22 from 1:30 p.m. - 3:30 p.m. and will be available to downlink sites nationally.

Ms. Gebbie was recently appointed by President Clinton to her current position as AIDS Policy Coordinator -- a job commonly called AIDS Czar. She is a former state health official in both Washington and Oregon and served on the first Presidential AIDS Commission. A nurse by training, Ms. Gebbie is currently a doctoral candidate in the PEW Doctoral Program in Health Policy at the University of Michigan School of Public Health in Ann Arbor, Michigan.

Although her speaking engagements will be limited during the first few months while she establishes her office in Washington, Ms. Gebbie has agreed to travel to West Virginia because of the importance of making everyone aware of the significance of the spread of HIV/AIDS in rural communities.

For more information on downlink sites for the teleconference, contact John Chandler or Becky Carter in the Office of Communications at 558-8888 or 558-0684.



HELP *with* CHRONIC Pain PATIENTS

NORTHERN WEST VIRGINIA PAIN MANAGEMENT CENTER IS AVAILABLE TO HELP WITH CHRONIC PAIN PATIENTS. WE SPECIALIZE IN CANCER PAIN, BACK PAIN, SYMPATHETIC DYSTROPHIES, MYOFASCIAL PAIN AND HEADACHES.

WITH TWO CONVENIENT LOCATIONS:

99 J.D. ANDERSON DR.
MORGANTOWN, WV

DOCTORS OFFICE BLDG.
SUITE 205
CLARKSBURG, WV

Richard M. Vaglienti, MD, F.A.C.P.M.
Matthew E. Midcap, MD, F.A.C.P.M.
Stanford J. Huber, MD

Northern West Virginia Pain Management Center

For More Information or Patient Referrals Call

1-800-221-6141

ROBERT C. BYRD HEALTH SCIENCES CENTER

OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Emergency Medicine Department created

Prescott

On September 1, the WVU School of Medicine created the Department of Emergency Medicine and Dr. John Prescott, F.A.C.E.P., was named chair.

The department is the 33rd to be established at a medical school in the U.S., says Dr. Prescott. The 11 Emergency Medicine faculty are all formerly members of the Department of Surgery.

"Our time really has come," says Dr. Prescott. "In the past year, the emergency medicine section has established a certified residency program, accepted the first students into a joint master's degree with the physician assistant program at Alderson-Broaddus College and has been awarded a $3 million federal grant."

The federal grant supports the Center for Rural Emergency Medicine and the WVU Injury Control Center.

WVU first to treat patients with voice impairment drug

WVU physicians are the first in the state to treat spasmodic dysphonia, a disorder characterized by an intermittent inability to speak, with botulinum toxin or BOTOX.

"For years, physicians tried to treat this disorder with speech therapy, psychology, surgery and sedatives," says Dr. Hassan Ramadan, of the Department of Otolaryngology. "Not until recently was it discovered that these patients could be helped by BOTOX, a drug frequently used by neurologists."

Individuals suffering from spasmodic dysphonia experience excessive closing of their vocal cords, and Dr. Ramadan says BOTOX can regulate this closing. Even though BOTOX has not yet been approved by the FDA for use in treating spasmodic dysphonia, the American Academy of Otolaryngology - Head and Neck Surgery, considers it the treatment of choice. Dr. Ramadan adds that medical centers around the country have seen positive results with this drug.

Patients treated with BOTOX receive injections every three to six months. Dr. Ramadan says no side effects have been reported.

Neurology chair elected VP of APBN

Gutmann

Dr. Ludwig Gutmann, professor and chair of neurology, has been named vice president of the American Board of Psychiatry and Neurology (ABPN) for 1994.

Dr. Gutmann is currently serving his seventh year as a director of ABPN; he also serves as the organization's treasurer. The ABPN is the only American Board of Medical Specialties' board that services two specialties; therefore, it is divided into two councils -- one for neurology and one for psychiatry. During 1994, Dr. Gutmann will also serve as chair of the neurology council.

Data on Teratogen available via MARS

The Department of Obstetrics and Gynecology began a Teratogen Information Service in July. The free service, available only to physicians, nurse midwives and other health care professionals, provides current, updated information about exposures during pregnancy.

Samuel Rauch, a genetics associate in OB/GYN, is coordinating the service which subscribes to TERIS (Teratogen Information Service) from the University of Washington, and ReproTox from Columbia Women and Children's Hospital in Washington, DC. This program was made possible by a grant from the West Virginia Chapter of the March of Dimes.

Call 1-800-WVA-MARS for more details.

St. Joseph's, Boone Memorial to become part of MDTV network

As of February 1, 1994, physicians and other health care providers at St. Joseph's Hospital in Buckhannon and Boone Memorial Hospital in Madison, will be linked to the Mountaineer Doctor Television (MDTV) network.

This two-way audio and video communications network allows rural hospitals and physicians nearly instant access to the technological and medical resources of the Robert C. Byrd Health Sciences Center.

The addition of these two hospitals will bring to seven the total number of sites on the MDTV network. It is currently operating at hospitals in New Martinsville, Petersburg and Elkins, and at the two campuses of the Health Sciences Center in Morgantown and Charleston.

New director named for Occupational and Environmental Health

Dr. Janie R. Vale is the new clinical director for the Institute of Occupational and Environmental Health. She previously practiced occupational medicine and non-surgical orthopedics with the Columbia (Mo.) Orthopaedic Group.

Dr. Vale's goal is to provide comprehensive outpatient and inpatient services for injured and ill workers in West Virginia and the region. Services will include the diagnosis, treatment, rehabilitation, and prevention of work-related injury and illness. Special emphasis will also be placed initially on soft tissue problems.

The Laser Surgery Center

- 35-bed JCAHO Accredited Hospital
- Ambulatory Care/ Same Day Surgery

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH

EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD
Robert E. Pollard, MD

Specializing in
Head and Neck Cancer Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)
FAX (304) 353-0215

HealthCare Financial Services "Your Medical Collection Specialists"

Looking for an edge in healthcare collections?

HFS provides **statewide** service, complete with:

* Automated dialer
* Statewide wats service
* Effective collections on medical accounts
* Trained, experienced staff
* Prompt account acknowledgement

HFS

A division of Strategic Health Services, Inc. • Affiliated with Charleston Area Medical Center

1204 Kanawha Boulevard, East • P.O. Box 3882 • Charleston, WV 25338
Phone: (304) 345-4371 • (800) 369-4371 • Fax: (304) 345-4323

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

Biomedical sciences program awarded Center of Excellence

The biomedical sciences program at Marshall University has been named the school's second Center of Excellence in honor of its exceptional accomplishments in quality undergraduate liberal arts education, rural health care, schools and schooling, fine arts and humanities, and economic development, according to MU President J. Wade Gilley.

"In addition to giving Marshall its first stand-alone Ph.D. program, the biomedical sciences program attracts millions of dollars a year in federal research support," Gilley said. "Right now, three faculty members are working on potentially patentable discoveries that could easily bring biotechnology companies to Huntington.

"The program's top 10 grants already have won $8.5 million in federal grants and contracts," Gilley said. "This is an exemplary program with almost limitless possibilities. Certainly it will continue to support the medical, educational and economic interests of our community," he added.

School of Medicine Dean Charles H. McKown Jr. applauded the efforts of faculty members in developing the program.

"This has been an outstanding program for many years by virtue of the ability and the dedication of our basic science faculty," McKown said. "Its level of excellence was authenticated when the program became accredited almost immediately after the Board of Trustees formally transferred it to Marshall."

The program is a combined effort by the departments of Anatomy, Biochemistry, Microbiology, Pharmacology and Physiology. In addition to teaching first- and second-year medical students, faculty members in these departments also teach graduate students who are seeking master's and Ph.D. degrees in biomedical science.

Dr. L. Howard Aulick, assistant dean for research development, said the program will be defined by its national competitiveness and its regional relevance.

"The Biomedical Sciences Center of Excellence will focus on research and graduate education which emphasize basic mechanisms of normal biological function and how these mechanisms are altered by the environment, heredity, disease or injury," Aulick commented. "The program will remain relatively small and will emphasize quality rather than quantity," he added.

Faculty members already study such local problems as high blood pressure, diabetes, cancer and environmental toxins. Aulick noted that Marshall researchers have an edge in translating such basic research into clinical reality because of the stable population base that makes it easier to conduct long-term trials and to study environmental and genetic influences on health.

"Since collaborative exchange with other institutions will be essential for our sustained growth and development, we will establish a monthly Visiting Scholars Seminar Program," Aulick explained. "By bringing in key scientists from neighboring institutions, we can introduce our biomedical sciences program to the larger scientific community at the same time we are strengthening our faculty, staff and students."

Aulick said a long-range planning committee has already begun working on issues of research and curriculum development. A ceremony to commemorate the program's Center of Excellence designation will be arranged later this fall.

New course promotes rural health and disease prevention

Marshall internists, pediatricians and family practitioners have joined forces to give entering students a course that blends the rural/primary care emphasis of West Virginia's medical education initiatives with the preventive emphasis common to many of the nation's health care reform plans.

The nine-hour course, Introduction to Health Promotion and Disease Prevention, implements curricular changes from the rural health initiatives at the MS-I level. Corresponding enhancements in the MS-II year will begin next fall.

"This course combines concepts of biostatistics/epidemiology with community medicine and Appalachian culture to provide a comprehensive view of primary care," said Dr. Linda Savory, assistant dean for curriculum and evaluation. "In addition to attending lectures, students take field trips to rural communities, get clinical experience in primary care, and participate in small-group discussions led by primary care physicians. The course is being very well received," she added.

Cancer specialist to lecture in December

Dr. Karen A. Johnson of the National Cancer Institute will speak on breast cancer prevention and treatment at Marshall University on December 4 at 1:30 p.m. in the Alumni Lounge of the Memorial Student Center.

Dr. Johnson, who holds both M.D. and Ph.D. degrees, is a CCOP director in the NCI's Community Oncology and Rehabilitation Branch of the Early Detection and Community Oncology Program. Prior to her presentation, Dr. Johnson will participate in grand rounds at St. Mary's Hospital. Her talk will be followed by a reception and a panel discussion with area oncologists, surgeons, and OB/GYNs.

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

Your CPA: Making Taxes Less Taxing

Question: The evening news just called, saying they'd like to see your tax return. Your first impulse is to call:

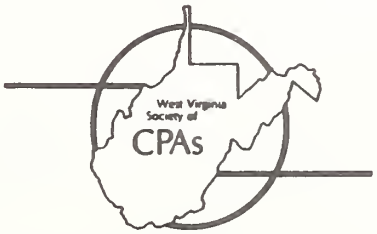
- ☐ a. An arsonist.
- ☐ b. Your "significant other."
- ☐ c. Your guru.
- ☐ d. Your mommy.
- ☑ e. Your CPA!

Answer: Give yourself two points if you chose your CPA. Your Certified Public Accountant has the most current knowledge of individual and corporate tax planning opportunities and the requirements of tax law. This means they can use their knowledge to reduce your year-end tax liability and your tax burden.

Whether your CPA is a company employee or an outside consultant, this professional can provide management advisory services, accounting, auditing, financial and tax planning. Members of The West Virginia Society of CPAs bring high professional standards to their work, backed by the resources of a 1,600-member professional association.

If you want information on reducing your tax liability, write for a free brochure to The West Virginia Society of CPAs, Department A, P.O. Box 1142, Charleston, WV 25324.

When you want to make a sound investment in your business, use a CPA.



Obituaries

Frank J. Gavlas, M.D.

Frank J. Gavlas, M.D., 74, of Martinsburg, died August 26 in City Hospital.

Dr. Gavlas graduated from the University of Arkansas School of Medicine in 1954 and completed his internship and residency at Valley Forge Army Hospital. He moved to Martinsburg in 1955 and specialized in orthopedics in private practice until 1974, when he joined the staff of the Veterans Affairs Medical Center Outpatient Department, where he worked until his retirement in 1989.

A veteran of World War II, Dr. Gavlas served with the U.S. Army Air Corps as an Air Cadet, and with the U.S. Army Reserves from 1954-61.

Dr. Gavlas had been a member of the WVSMA since 1957 and was also a member of the AMA, the Eastern Panhandle Medical Society, the Knights of Columbus, the National Association of Retired Federal Employees and the American Association of Retired Persons. He was also a member of St. Joseph's Catholic Church.

Survivors include his wife, Arline C. (Campbell) Gavlas; two sons, James F. of Mercerville, N.J., and John T. of Charles Town; one daughter, Peggy G. Meckling of Cross Junction, Va.; two sisters, Rosemary Wamsley of Jacksonville, Ala., and Rita Keilch of Little Rock, Ark.; three grandchildren, Anne-Marie, Sean and Kimberly Gavlas of Mercerville; and two nephews and one niece.

Memorial contributions can be made to the Oncology Unit of City Hospital c/o Bernie Raney, or the charity of one's choice.

Wallace B. Lilly, M.D.

Dr. Wallace B. "Pete" Lilly, 74, of Beckley died September 1 in a Charleston hospital after a long illness.

Dr. Wallace was a native of Beckley who received his medical degree in 1944 from the Medical College of Virginia, where he also interned. He completed his residency at Beckley Hospital in 1946 and then practiced medicine in Beckley for 47 years, specializing in obstetrics and gynecology.

A member of the WVSMA since 1948, Dr. Wallace was also a member of the AMA, the Raleigh County Medical Society and the Beckley Rotary Club. He was an Army veteran.

Dr. Lilly was preceded in death by two sisters, Hilda Lilly and Edna Kessel, and two brothers, J.G. "Gap" and Nathan Lilly.

Survivors include his wife, Mabel Dodson Lilly; son, Peter B. Lilly and his wife, Brenda E., of Charleston; daughter, Mrs. Clark (Susan Elizabeth) Lowe of Martinez, Ga.; sister, Mrs. Lorena Ball of Beckley; and six grandchildren, Lauren and Peter Lilly, Marc, Carter and Kelly Noland and Steven Lowe.

Marshall J. Thomas, M.D.

Dr. Marshall J. Thomas, M.D., 92, an eye, ear, nose and throat specialist who formerly practiced in Huntington and in Cambridge, Ohio, died on August 25 in Portland, Ore., at the retirement home where he was residing.

Dr. Thomas was the son of Charles Lewis Thomas and Emza Ridgeway Thomas and he was born on October 10, 1900 in Deucher, Ohio. He graduated from Wellsville High School in Wellsville, Ohio, in 1919 and then attended Ohio Wesleyan University, where he received an A.B. degree in 1924. In 1928, he obtained his medical degree from Ohio State University.

After graduating from Ohio State, Dr. Thomas went into general practice for eight years in Jeromesville, Ohio. He then did postgraduate studies in eye, ear, nose and throat medicine at Washington University in St. Louis and at Starling-Loving Hospital in Columbus, Ohio. Following his postgraduate work, Dr. Thomas practiced as an E.E.N.T. specialist in Cambridge, Ohio, and in Huntington until his retirement in 1970.

Upon his retirement, Dr. Thomas and his wife, Mabel McCormick Thomas, moved to San Diego, Calif. His wife died the next year, and in 1973 he remarried Mary Andrews Stonebreaker and they lived in Florida until her death in 1986. Dr. Thomas then relocated to Eugene, Ore., to be with his son, Marshall. He had recently moved to a retirement home in Portland, where was living at the time of his death.

A member of the WVSMA since 1946, Dr. Thomas was also a member of the AMA and the F & A Masons of Wellsville, Ohio.

Dr. Thomas is survived by his son, Marshall McCormick Thomas, and his wife, Louann, of Lake Oswego, Ore.

Society News

Raleigh

At their September meeting, the members took actions on three membership matters.

Dr. Joseph Askoy of Beckley was made an active member, and Dr. Walter Klingensmith and Dr. Teofilo Rojas were changed from active status to retired status. The members noted that Drs. Klingensmith and Rojas had made the decision to retire based to a great extent on the current problems imposed on their practices by state and national laws.

STICK WITH CHRISTMAS SEALS.® USE THEM TO FIGHT LUNG DISEASE.

AMERICAN LUNG ASSOCIATION®

1-800-LUNG-USA

Space contributed by the publisher as a public service.

DOCTORS NEEDED.

More than anyone else, YOU have the power to convey the importance of mammography to your patients.

While regular mammograms are important for women over 40, the risk of breast cancer increases with age, so it becomes critically important that all women over 50 have a mammogram every year.

Annual mammography is crucial for early detection and intervention—it is a woman's only true protection. Yet too many women are not hearing this message.

So no matter what your specialty, the American Cancer Society needs you to recommend an annual mammogram for every woman over 50.

Take the first step.

Call 1-800-ACS-2345 for information and literature that can help you make an impact.

EXERCISE YOUR POWER TO SAVE LIVES.

Ad Council A Public Service of This Publication

give the word.

MAMMOGRAM

EVERY YEAR AFTER 50

AMERICAN CANCER SOCIETY®

Annual Audit 1992

The annual audit of the West Virginia State Medical Association for the calendar year 1992 has been completed by Ernst & Young of Charleston. The complete audited financial statements including the report of independent auditors is as follows:

REPORT OF INDEPENDENT AUDITORS

To the Council
West Virginia State Medical Association

We have audited the accompanying balance sheets of West Virginia State Medical Association (the Association) as of December 31, 1992 and 1991, and the related statements of revenues and expenses—unrestricted fund, changes in fund balances, and cash flows—unrestricted fund for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of West Virginia State Medical Association at December 31, 1992 and 1991, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young

April 30, 1993

BALANCE SHEETS—WVSMA

UNRESTRICTED FUND	December 31 1992	1991
ASSETS		
Cash and cash equivalents	$ 721,859	$ 645,982
Investments, at cost (market value $203,125 and $206,082 as of December 31, 1992 and 1991)—Note A	200,035	200,035
Accounts receivable	35,971	49,078
Other assets	16,719	9,433
Land, building, and equipment, net—Note B	641,360	662,467
	$1,615,944	$1,566,995
LIABILITIES		
Dues collected in advance	$ 552,758	$ 524,156
Medical scholarship obligation	13,663	13,663
Accounts payable	28,556	28,393
Accrued income taxes payable	7,706	12,538
Accrued expenses and other liabilities	33,236	39,055
Note payable to bank—Note D	502,616	514,198
	1,138,535	1,132,003
FUND BALANCE		
Undesignated	477,409	434,992
	$1,615,944	$1,566,995

RESTRICTED FUND—NOTE A		
ASSET		
Investment in common stock	$ 4,250	$ 4,250
FUND BALANCE		
Endowment	$ 4,250	$ 4,250

See notes to financial statements.

STATEMENTS OF REVENUES AND EXPENSES—UNRESTRICTED FUND—WVSMA

	Year Ended December 31 1992	1991
REVENUES		
Dues	$ 748,995	$ 778,750
Professional liability services—Note E	140,000	140,000
Contributions:		
Legislative	8,495	100,085
Conferences and meetings	7,021	24,404
Interest and investment	41,002	41,813
Exhibit space income	51,200	27,613
Advertising	63,265	58,663
Registration fee income	42,705	43,860
Management fee income	5,000	20,000
IC Systems commission income	7,343	7,821
Other revenues	20,997	9,969
TOTAL REVENUES	1,136,023	1,252,978
EXPENSES		
Salaries and wages	289,790	316,680
Legislative	43,981	100,085
Interest expense—Note D	50,951	51,710
Publishing and printing	91,777	89,772
Convention speakers and supplies	94,904	94,839
Legal and accounting	76,889	66,667
Travel	85,659	70,632
Malpractice	29,132	28,046
Employee benefits—Note G	68,531	79,704
Depreciation and amortization	28,250	36,657
Postage	37,556	29,160
Payroll taxes	24,011	23,557
Office supplies	23,804	15,616
Telephone	15,824	18,552
President's stipend	5,000	5,000
Property taxes	11,395	10,717
Liability insurance	7,106	7,299
Medical students'/residents' subsidies	6,665	6,296
Computer repairs and maintenance	6,630	6,757
Utilities	6,792	6,721
Other expenses	98,174	90,250
Refund of expenses	(7,695)	(8,953)
TOTAL EXPENSES—NET	1,095,126	1,145,764
EXCESS OF REVENUES OVER EXPENSES	$ 40,897	$ 107,214

See notes to financial statements.

STATEMENTS OF CHANGES IN FUND BALANCES—WVSMA

	Unrestricted Fund	Restricted Endowment Fund
Balance at December 31, 1990	$ 320,188	$ 4,250
Change in unrealized loss on equity securities	6,118	
Excess of revenues over expenses	107,214	1,472
Transfer from endowment fund to unrestricted fund	1,472	(1,472)
Balance at December 31, 1991	434,992	4,250
Excess of revenues over expenses	40,897	1,520
Transfer from endowment fund to unrestricted fund	1,520	(1,520)
Balance at December 31, 1992	$ 477,409	$ 4,250

See notes to financial statements.

STATEMENTS OF CASH FLOWS—UNRESTRICTED FUND—WVSMA

	Year Ended December 31 1992	1991
OPERATING ACTIVITIES		
Excess of revenues over expenses	$ 40,897	$ 107,214
Adjustments to reconcile excess of revenues over expenses to net cash provided by operating activities:		
Depreciation and amortization	28,250	36,657
Decrease (increase) in accounts receivable	13,107	(20,853)
Increase in other assets	(7,286)	(8,127)
Increase in dues collected in advance	28,602	366,176
Decrease in income taxes payable	(4,832)	(5,791)
Decrease in medical scholarship obligations		(3,000)
Increase in accounts payable	163	15,408
Decrease in accrued expenses and other liabilities	(5,819)	(24,526)
Transfer from Endowment Fund	1,520	1,472
NET CASH PROVIDED BY OPERATING ACTIVITIES	94,602	464,630
INVESTING ACTIVITIES		
Purchases of equipment	(7,143)	(2,697)
NET CASH (USED IN) INVESTING ACTIVITIES	(7,143)	(2,697)
FINANCING ACTIVITIES		
Repayment of note payable to bank	(11,582)	(10,823)
NET CASH (USED IN) FINANCING ACTIVITIES	(11,582)	(10,823)
NET INCREASE IN CASH	75,877	451,110
Cash and cash equivalents at beginning of year	645,982	194,872
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 721,859	$ 645,982

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS—WVSMA

December 31, 1992

NOTE A—SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Cash and Cash Equivalents: Cash and cash equivalents are comprised of short-term certificates of deposit recorded at cost, which approximates market.

Investments: Investments consist of approximately 17,300 shares of a Federated GNMA Trust which are stated at the lower of cost or market value. There were no sales of investments in 1992 or 1991. At December 31, 1992, the gross unrealized gain pertaining to the equity securities was $3,090. Changes in gross unrealized securities gains and losses through April 30, 1993 are not material.

Land, Building, and Equipment: Land, building, and equipment are recorded at historical cost. Depreciation is computed by the straight-line method using estimated useful lives ranging from 5 to 35 years. The cost of maintenance and repairs is charged to income as incurred, and significant improvements are capitalized.

Allowance for Doubtful Accounts: The Association values its accounts receivable at net realizable value by expensing amounts determined to be uncollectible in the period of determination.

Medical Scholarship Obligation: Until 1987, the Association provided scholarships to students attending Schools of Medicine at West Virginia and Marshall Universities for the purpose of defraying expenses incurred by such students. A liability for the remaining scholarship obligation is a part of the general fund.

Fund Balance: The Endowment Fund, a restricted fund, was established to pay for the guest speaker at the annual meeting and consists of equity securities stated at cost, which approximates market value.

Recognition of Revenue: Members are billed in October for the subsequent year's dues, which are treated as earned in the period to which they relate. All dues received prior to January 1 are reported as dues collected in advance. In 1991, the Association received special contributions from its members to promote the concerns of the membership with respect to legislative rules and regulations which affect the practice of medicine in the State of West Virginia. The Association paid lobbying and legislative update expenses totalling $43,981 and $100,085 in 1992 and 1991, respectively.

Reclassifications: Certain amounts reported in 1991 have been reclassified to conform with 1992 presentation. Such reclassifications had no impact on the excess of revenues over expenses.

NOTE B—LAND, BUILDING, AND EQUIPMENT

A summary of land, building, and equipment, and the related allowance for depreciation as of December 31, is as follows:

	1992	1991
Land	$ 141,247	$ 141,247
Building and improvements	635,585	635,585
Furniture and equipment	219,526	212,383
	996,358	989,215
Less allowance for depreciation	(354,998)	(326,748)
	$ 641,360	$ 662,467

NOTE C—FUTURE MINIMUM RENTALS UNDER OPERATING LEASES

The Association leases office and computer equipment under noncancellable operating leases with terms of one year or more. The following is a schedule by years of minimum future rentals for the years ending December 31:

1993	$16,000
1994	21,000
1995	3,100
Total minimum future rentals	$40,100

Total minimum future rentals do not include contingent rentals which may be assessed under the office equipment lease on the basis of usage in excess of stipulated minimums. Contingent rental expense in 1992 and 1991 approximated $1,500 and $600, respectively.

Rental expense in 1992 and 1991 approximated $18,000 and $12,000, respectively.

NOTE D—DEBT

Terms of the agreement underlying the note payable to bank provide for interest at 10% with monthly installments of $5,211 (including principal and interest) with a balloon payment in 1993. The loan is collateralized by a first deed of trust on the building which had a net book value of approximately $468,000 at December 31, 1992, and $503,000 at December 31, 1991. The Association is currently working on refinancing arrangements for the $502,616 note which is scheduled to mature in 1993.

Interest paid approximated $51,000 and $52,000 in 1992 and 1991, respectively.

NOTE E—PROFESSIONAL LIABILITY SERVICES

The Association has separate agreements with Continental Insurance Agency (CNA) and McDonough Caperton Insurance Group, L.P. (MCIG) to provide educational and marketing services to the Association's members relating to professional liability insurance. Under the terms of the agreements, the Association is to receive up to $100,000 a year from each company. The Association recognized income of $100,000 from CNA and $40,000 from MCIG in 1992 and 1991.

NOTE F—INCOME TAXES

Revenues of the Association are generally exempt from federal income tax under Section 501 (c) (6) of the Internal Revenue Code. However, certain income, primarily advertising revenues and income received under agreements with insurance providers for their educational and marketing services and use of the Association's membership lists, is considered unrelated business income and is taxable to the extent it exceeds allocable expenses.

The Association paid income taxes approximating $4,800 and $5,800 in 1992 and 1991, respectively.

NOTE G—RETIREMENT PLAN

The Association is a participant in a Prototype Corporate Defined Contribution Retirement Plan (the Plan). All employees of the Association are covered by the Plan as long as they are at least twenty-one years old and have completed six months of service. The Association's contribution approximated $23,000 and $29,000 in 1992 and 1991, respectively, based on 10% of the total compensation of all eligible participants. Employees are vested in their participant account at the rate of 20% for each completed year of service, and up to 100% vesting after five years of service.

Joseph G. Feghali, MD

Glaucoma Consultation and Surgery

Member of the American Glaucoma Society

- Specializes in pediatric and adult glaucoma
- Computerized optic nerve tomography: a quantitative scanning laser method to assess optic nerve tissue damage from glaucoma
- Glaucoma drainage implants: an established new surgical procedure for refractory and high-risk glaucoma cases

Joseph G. Feghali, MD - 2000 Hampton Center, Suite D - Morgantown, WV 26505
For appointments, call: (304) 599-6627 or (800) 333-6627

THE MYERS CLINIC — Philippi, West Virginia

Notice: Seeking Internal Medicine, Pediatrics, and/or Family Practice, must be Board Certified or Board Eligible.

Contact: Lonnie L. Crane, 112 North Woods Street, Philippi, WV 26416.
1-(304) 457-2800

Radiology:
Halberto G. Cruz, M. D.

Pathology:
Fulvio Franyutti, M. D.

Surgery:
J. W. Woodford, M. D.

Pediatrics:
E. G. Kreider, M. D.

Internal Medicine:
Karl J. Myers, Jr., M. D.
Z. Moussa, M. D.

Easter Seals

making a difference in the lives of West Virginians with disabilities

Two of the many services we provide include:

* State information and referral program connecting individuals with disabilities to appropriate agencies and professionals.
* State assistance program providing up to $100 for persons with documented needs to use toward evaluations, therapy and equipment.

For more information, contact:

Easter Seal Rehabilitation Center
1305 National Road
Wheeling, WV 26003
(304) 242-1390 Voice or TDD (304) 242-1390 or (800) 677-1390

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENTS,
PUBLICATION COMMITTEE
Linn M. Mangano, M.D., Morgantown
Clinton Hale Sutherland, M.D., Huntington

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

Feature Article
Roll call votes affecting health care providers 486

Scientific Newsfront
Update on therapy for atrial fibrillation 490
Manuscript Guidelines 493
Giant posterior inferior cerebellar artery aneurysm associated with foramen magnum syndrome 494
The gynecologist and treatment of carcinoma of the breast 496

President's Page
WVSMA advocates change 500

Editorial
The split in medicine 502

In My Opinion
Clinton plan unnecessarily complex 503

Special Departments
General News 504
Mid-Winter Clinical Conference Preliminary Program 506
Mid-Winter Clinical Conference Registration Form 507
Continuing Medical Education 508
Medical Meetings/Poetry Corner 509
Bureau of Public Health News 512
Robert C. Byrd Health Sciences Center News 514
Marshall University School of Medicine News 516
For Your Benefit 518
Alliance News 520
Obituary/Society News 521
New Members/WESPAC Members 522
1994 Advertising Rates 524
Classified 525
November Advertisers 526

Front Cover
A river otter takes a break from swimming at French Creek Game Farm in Upshur County. Photo courtesy of *Stephen J. Shaluta Jr.,* West Virginia Division of Tourism and Parks.

Roll call votes affecting health care providers

Editor's Note: *This article shows the voting records of the members of the House of Delegates and the Senate on several key pieces of health care legislation which were passed or considered during the 1993 session of the West Virginia Legislature. The data concerning the House of Delegates was compiled by the West Virginia State Republican Party and the voting records of the Senate members were compiled by the WVSMA.*

HOUSE OF DELEGATES ROLL CALL VOTES AFFECTING HEALTH CARE PROVIDERS

Delegate		County	Percentage Favorable Votes	Roll Call Votes * 1	2	3	4	5	6	7	8	9	10
Adkins	D	Wayne	33	+	-	-	-	+	-	A	A	A	A
Anderson	R	Wood	70	+	-	+	-	+	+	+	+	-	+
Ashcraft	D	Harrison	0	A	A	A	A	A	-	-	-	-	-
Ashley	R	Roane	50	+	-	-	+	-	+	-	+	-	+
Beach	D	Monongalia	0	-	-	-	-	-	-	-	-	-	-
Beane	D	Wood	60	+	-	-	-	-	+	+	+	+	+
Bennett	D	Taylor	30	+	-	-	+	+	-	-	-	-	-
Border	R	Wood	90	+	+	+	+	+	+	+	+	-	+
Brown	D	Kanawha	0	-	-	-	-	-	-	-	-	-	-
Browning	D	Wyoming	0	-	-	-	-	-	-	-	-	-	-
Brum	D	Wood	70	+	-	+	-	+	+	+	-	+	+
Burk	R	Wood	60	+	-	+	-	-	+	+	+	-	+
Campbell	D	Braxton	0	-	-	-	-	-	-	-	-	-	-
Carper	D	Mercer	20	+	-	+	-	-	-	-	-	-	-
Chambers	D	Cabell	0	-	-	-	-	-	-	-	-	-	-
Collins	D	Tucker	0	-	-	-	-	-	-	-	-	-	-
Compton	D	Monroe	0	-	-	-	-	-	-	-	-	-	-
Cook, D.	D	Boone	0	-	-	-	-	-	-	-	-	-	-
Cook, S.	D	Monongalia	0	-	-	-	-	-	-	-	-	-	-
Dempsey	D	Lincoln	0	-	-	-	-	-	-	-	-	-	-
Douglas	D	Berkeley	0	-	-	-	-	-	-	-	-	-	-
Doyle	D	Jefferson	0	-	-	-	-	-	-	-	-	-	-
Ellis	D	Logan	50	+	-	+	+	+	-	-	+	-	-
Evans	R	Grant	70	+	-	+	+	+	+	-	+	+	-
Everson	D	Barbour	33	+	-	A	+	+	-	-	-	-	-
Facemyer	R	Jackson	70	+	-	-	+	+	+	+	+	-	+
Faircloth	R	Berkeley	50	+	-	-	-	+	-	+	+	-	+
Fantasia	D	Marion	0	-	-	-	-	-	-	-	-	-	-
Farris	D	Kanawha	10	-	-	-	-	+	-	-	-	-	-
Fealy	D	Lewis	0	-	-	-	-	-	-	-	-	-	-
Flanigan	D	Mercer	10	-	-	-	-	-	-	-	-	+	-
Fragale	D	Harrison	44	+	-	+	-	+	-	-	A	+	-
Gallagher	D	Monongalia	50	+	-	+	+	-	-	-	+	+	-
Harrison	R	Kanawha	70	+	-	+	+	+	+	-	+	+	-
Heck	D	Wayne	10	+	-	-	-	-	-	-	-	-	-
Henderson	R	Kanawha	90	+	+	+	+	+	+	+	+	+	-
Hendricks	D	Logan	50	+	-	+	+	+	-	-	+	-	-
Higgins	D	Brooke	56	+	-	+	+	+	A	+	-	-	-
Houvouras	D	Cabell	0	-	-	-	-	-	-	-	-	-	-
Huffman	D	Mercer	70	+	-	+	-	+	+	-	+	+	+
Huntwork	D	Cabell	0	-	-	-	-	-	-	-	-	-	-
Johnson	D	Nicholas	20	-	-	-	-	+	-	-	-	+	-

* + Vote Favorable to Medical Providers - Vote Detrimental to Medical Providers A Absence

HOUSE OF DELEGATES ROLL CALL VOTES AFFECTING HEALTH CARE PROVIDERS

Delegate		County	Percentage Favorable Votes	Roll Call Votes * 1	2	3	4	5	6	7	8	9	10
Kessel	D	Kanawha	100	+	+	+	+	+	+	+	+	+	+
Kiss	D	Raleigh	0	-	-	-	-	-	-	-	-	-	-
Leach	D	Cabell	0	-	-	-	-	-	-	-	-	-	-
Leggett	R	Pleasants	90	+	+	+	+	+	+	+	+	-	+
Linch	D	Harrison	44	+	-	-	-	+	A	-	+	+	-
Lindsey	D	Brooke	40	A	A	A	A	A	-	+	+	-	-
Louisos	D	Fayette	90	+	+	+	+	+	+	+	+	-	+
Love	D	Hancock	30	+	-	-	-	-	-	+	-	-	+
Manuel	D	Jefferson	0	-	-	-	-	-	-	-	-	-	-
Martin	D	Randolph	0	-	-	-	-	-	-	-	-	-	-
McGraw	D	Raleigh	0	-	-	-	-	-	-	-	-	-	-
McKinley	R	Ohio	80	+	+	+	+	-	+	+	+	-	+
Mezzatesta	D	Hampshire	0	-	-	-	-	-	-	-	-	-	-
Michael	D	Hardy	0	-	-	-	-	-	-	-	-	-	-
Miller, D.	D	Preston	0	-	-	-	-	-	-	-	-	-	-
Miller, M.	R	Kanawha	60	+	-	+	-	-	+	+	+	-	+
Moore	D	McDowell	0	A	A	A	A	A	-	-	A	-	-
Nesbitt	R	Kanawha	100	+	+	+	+	+	A	+	+	+	+
Nicol	D	Mineral	0	-	-	-	-	-	-	-	-	-	-
Oliverio	D	Monongalia	30	+	-	-	+	-	-	-	-	-	+
Overington	R	Berkeley	100	+	+	+	+	+	+	+	+	+	+
Paxton	D	Putnam	0	-	-	-	-	-	-	-	-	-	-
Peterson	D	Fayette	30	-	-	+	-	-	-	-	-	+	+
Pethtel	D	Wetzel	0	-	-	-	-	-	-	-	-	-	-
Pettit	D	Hancock	30	+	-	-	-	-	-	+	-	-	+
Phillips	D	Putnam	10	-	-	-	-	-	+	-	-	-	-
Pino	D	Fayette	80	+	+	+	+	+	+	+	+	-	-
Preece	D	Mingo	0	-	-	-	-	-	-	-	-	-	-
Prezioso	D	Marion	20	-	-	+	-	-	+	-	-	-	-
Proudfoot	D	Randolph	20	+	-	-	-	+	-	-	-	-	-
Pulliam	D	Raleigh	100	+	+	+	+	+	+	+	+	+	+
Reed	D	Raleigh	25	A	A	A	A	A	A	-	-	+	-
Richards	R	Cabell	89	+	+	+	+	+	A	+	+	-	+
Riggs	R	Upshur	0	A	A	A	A	A	A	-	-	-	-
Rowe	D	Greenbrier	0	-	-	-	-	-	-	-	-	-	-
Rutledge	D	Kanawha	0	-	-	-	-	-	-	-	-	-	-
Ryan	D	Summers	80	+	+	+	+	+	-	+	+	-	+
Schoonover	D	Clay	0	-	-	-	-	-	-	-	-	-	-
Smith	D	Kanawha	0	-	-	-	-	-	-	-	-	-	-
Sorah	D	Kanawha	0	-	-	-	-	-	-	-	-	-	-
Spencer	D	Kanawha	10	-	-	-	-	-	-	-	-	+	-
Staton	D	Wyoming	0	-	-	-	-	-	-	-	-	-	-
Stewart	D	Marion	0	-	-	-	-	-	-	-	-	-	-
Talbott	D	Webster	80	+	-	+	+	+	A	A	A	A	A
Tribbett	D	Marshall	30	-	+	-	-	+	-	+	-	-	-
Trump	R	Morgan	50	-	-	-	-	-	+	+	+	+	+
Varner	D	Marshall	10	-	-	-	-	-	-	+	-	-	-
Vest	D	Putnam	40	+	+	+	-	-	-	-	-	+	-
Wallace	R	Greenbrier	90	+	+	+	+	-	+	+	+	+	+
Walters	R	Kanawha	44	A	-	-	-	-	-	+	+	+	+
Warner	D	Harrison	71	+	-	+	-	+	+	A	A	A	+
White, H.	D	Mingo	40	+	-	-	+	+	-	-	+	-	-
White, L.	R	Ohio	80	A	A	A	A	A	+	+	+	-	+
White, P.	D	Putnam	0	-	-	-	-	-	-	-	-	-	-
Whitman	D	Logan	0	-	-	-	-	-	-	-	-	-	-
Williams	D	Cabell	30	-	-	-	-	-	+	+	-	-	+
Willison	R	Tyler	40	+	-	+	-	-	-	+	+	-	-
Yeager	D	McDowell	0	-	-	-	-	-	-	-	-	-	-

* + Vote Favorable to Medical Providers - Vote Detrimental to Medical Providers A Absence

Vote explanation - 1993 WV House of Delegates health care providers' scorecard

1. **6-Year Lawsuit Limitation.** April 18, 1993. Amendment to change the limitation for which medical malpractice lawsuits may be filed from a maximum of 10 years to six years from the date of occurrence. Most states in the nation have two or four-year limits. Motion failed 44-49. The medical position favored changing this to six years.

2. **Periodic Payments.** April 18, 1993. Amendment to allow for periodic payments of awards for personal injuries from medical malpractice. Similar legislation authorizing structured payments has been authorized in 35 states. Motion failed 15-79. The medical position favored allowing periodic payments.

3. **Collateral Source Evidence.** April 18, 1993. Amendment to allow evidence of collateral source payments to be admissible so that the jury is informed of double or triple recoveries from an injury. In the past three years 29 states have passed this form of tort reform allowing juries to base awards on the most complete information possible and avoiding duplication of other benefits received by the plaintiffs. Motion failed 32-61. The medical position favored the amendment to eliminate double recoveries.

4. **Meritorious Claim Filing Requirement.** April 18, 1993. Amendment to require a meritorious claim affidavit to be attached to a complaint in professional liability and product liability actions, thereby reducing lawsuits filed without merit or evidence. Motion failed 26-68. The medical position favored this requirement.

5. **Limit Attorney Fees.** April 18, 1993. Amendment to limit attorney contingency fees in medical malpractice actions to 40% of the first $50,000; 33 1/3% of the next $50,000; 25% of the next $500,000; and 15% of the amount over $600,000. Motion failed 33-61. The medical position favored the limits.

6. **Medicaid Enhancement Tax.** April 21, 1993. S.B. 542 placing a gross receipts tax of 2.0% on doctors, 2.5% on hospitals, 5.5% on nursing homes, 1.25% on dentists, 5.0% on ambulances, etc. Bill passed 67-26 but died in conference. Medical position opposed this tax on health care services.

7. **Medicaid Rate Lower Near State Border.** May 22, 1993. Amendment lowering the Medicaid tax rate from 2% to 1% on physicians whose practice is within ten miles of the state border. In the Northern Panhandle 75% of the doctors are licensed to practice in a neighboring state; 35% have satellite offices out-of-state. Motion failed 31-66. Medical position favored this reduction of rate in competitive areas.

8. **Prepay Medicaid Tax.** May 22, 1993. Amendment to delete requirement for health care providers to estimate accounts payable for Medicaid by June 1 and to pay the taxes due on these accounts by June 20 before reimbursement. Motion failed 33-62. Medical position favored this amendment.

9. **Tobacco Tax Instead of Doctor Tax.** May 22, 1993. Amendment to replace the 2% Medicaid tax on doctors with a 25% wholesale tax on tobacco products. Doctors will pass the 2% cost on while a tobacco tax may reduce usage and health care costs. Motion failed 22-75. Medical position favored the tobacco tax.

10. **Medicaid Provider Tax.** May 22, 1993. S.B. 2 taxes gross receipts of health care providers at a rate of 2% for physicians; 1.75% for chiropractors, dentists, opticians, optometrists, psychologists, and podiatrists; 2.5% for hospitals; 5.5% for nursing homes; 5.5% for ambulance services; 5% for x-ray services. Bill passed 67-27. The medical position opposed this tax.

Senate roll call votes affecting health care providers

The following information provides the voting records of members of the West Virginia State Senate in regards to the Medicaid Provider Tax Bill and the Governor's Health Reform Proposal. The "**N**" signifies Nay votes which are votes favorable to health care. Please note that the Senate took no roll call votes on the tort reform amendments.

SB 2 - Medicaid Tax - Passed May 26, 1993 During the First Extraordinary Session (25 Yeas, 9 Nays)

Senator		County	
Anderson -	D	Summers	Y
Bailey -	D	Wayne	Y
Blatnik -	D	Ohio	Y
Boley -	**R**	**Pleasants**	**N**
Brackenrich -	D	Greenbrier	Y
Chafin -	D	Mingo	Y
Chernenko -	D	Brooke	Y
Claypole -	D	Monongalia	Y
Craigo -	D	Putnam	Y
Dalton -	D	Lincoln	Y
Dittmar -	D	Jackson	Y
Felton -	D	Preston	Y
Grubb -	**D**	**Kanawha**	**N**
Helmick -	**D**	**Pocahontas**	**N**
Holliday -	D	Fayette	Y
Humphreys -	**D**	**Kanawha**	**N**
Jones -	**D**	**Cabell**	**N**
Lucht -	**D**	**Berkeley**	**N**
MacNaughtan -	D	Wetzel	Y
Manchin -	D	Marion	Y
Minard -	D	Harrison	Y
Plymale -	D	Wayne	Y
Ross -	D	Pocahontas	Y
Sharpe -	D	Lewis	Y
Tomblin -	D	Logan	Y
Wagner -	D	McDowell	Y
Walker -	D	Kanawha	Y
Wehrle -	D	Kanawha	Y
Whitlow -	**D**	**Mercer**	**N**
Wiedebusch -	D	Marshall	Y
Withers -	D	Taylor	Y
Wooton -	**D**	**Raleigh**	**N**
Yoder -	**R**	**Jefferson**	**N**
Burdette -	D	Wood	Y

SB 290 - Governor's Health Reform Plan Passed During the 1993 Regular Session (28 Yeas, 5 Nays, 1 Absent)

Senator		County	
Anderson -	D	Summers	Y
Bailey -	D	Wayne	Y
Blatnik -	D	Ohio	Y
Boley -	**R**	**Pleasants**	**N**
Brackenrich -	D	Greenbrier	Y
Chafin -	D	Mingo	Y
Chernenko -	D	Brooke	Y
Claypole -	D	Monongalia	Y
Craigo -	D	Putnam	Y
Dalton -	D	Lincoln	Y
Dittmar -	D	Jackson	Y
Felton -	D	Preston	Y
Grubb -	**D**	**Kanawha**	**N**
Helmick -	D	Pocahontas	Absent
Holliday -	D	Fayette	Y
Humphreys -	D	Kanawha	Y
Jones -	D	Cabell	Y
Lucht -	D	Berkeley	Y
MacNaughtan -	**D**	**Wetzel**	**N**
Manchin -	D	Marion	Y
Minard -	D	Harrison	Y
Plymale -	D	Wayne	Y
Ross -	D	Pocahontas	Y
Sharpe -	D	Lewis	Y
Tomblin -	D	Logan	Y
Wagner -	D	McDowell	Y
Walker -	D	Kanawha	Y
Wehrle -	D	Kanawha	Y
Whitlow -	D	Mercer	Y
Wiedebusch -	D	Marshall	Y
Withers -	**D**	**Taylor**	**N**
Wooton -	D	Raleigh	Y
Yoder -	**R**	**Jefferson**	**N**
Burdette -	D	Wood	Y

Update on therapy for atrial fibrillation

STANLEY B. SCHMIDT, M.D.
Section of Adult Cardiology, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown
LARRY A. RHODES, M.D.
Section of Pediatric Cardiology, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

Abstract

This article reviews newer trends in the management of patients with atrial fibrillation. The roles of chronic antiarrhythmic therapy, anticoagulation, and non-pharmacologic treatments are discussed.

Introduction

Atrial fibrillation (AF) is a common arrhythmia which frequently causes troubling symptoms, and may lead to life-threatening complications. The results of recent studies have led us to reassess several established practices in managing these patients.

This article reviews the rationale behind these therapeutic trends, and presents data on some newer non-pharmacologic treatments for AF.

Epidemiology

The prevalence of AF increases with age, and this arrhythmia affects 2% to 4% or more of the population above 60 years of age (1). AF may be intermittent (paroxysmal) or chronic, and may alternate with atrial flutter. Many individuals with this arrhythmia have an underlying abnormality of cardiac structure.

In the past, AF was usually associated with rheumatic valve disease. Now, physicians have found that more common etiologies include hypertensive and ischemic heart disease, non-rheumatic valve disease (including calcified mitral annulus), and cardiomyopathy. Other contributing conditions may include hyperthyroidism, acute alcohol intoxication, pericarditis, cardiac surgery, pacemakers, and elevated vagal tone.

So-called "lone" AF exists when no such underlying factors are identified. In a recent study, nearly half of all cases were considered to be in this category (2), which is higher than older estimates of 2% to 31% from the Framingham Study (3).

In patients with rheumatic heart disease, AF is associated with a seventeenfold increase in the risk of stroke. In other patients, the risk is increased fivefold, corresponding to an annual incidence of approximately 4%. In patients younger than 60 years with lone AF, the risk of stroke is very low (< 0.1%/year) (4). In older patients, AF is a strong independent risk factor for stroke, even in those with lone AF (3). Contrary to previous impressions, chronic AF carries a greater risk of stroke than the intermittent, or paroxysmal form (5). Linked to the risk of thromboembolism is a doubling of total mortality among patients with AF (1).

Patient management

The goals of managing patients with AF are listed in Table 1. To this list might be added an additional goal of primary prevention through control of hypertension and other risk factors.

To begin treating a patient with AF, the first step is to confirm the diagnosis by electrocardiography. This is usually straightforward, but occasional cases of multifocal atrial tachycardia or digitalis toxicity may cause confusion. In addition, the associated presence of the Wolff-Parkinson-White (WPW) syndrome must be recognized (Figure 1).

Once the diagnosis is established, the first practical point is to assess for hemodynamic compromise. The three cardinal findings are hypotension, angina, and heart failure. If any of these is significant and does not respond quickly to treatment, the patient should be sedated and electrically cardioverted.

The next step is to slow the ventricular rate. This usually reduces symptoms and improves hemodynamic performance. Drugs available for this purpose are listed in Table 2. All of these drugs act on the AV node and impair conduction of atrial impulses to the ventricles. The response to digoxin is often disappointing, particularly in patients who are acutely ill or ambulatory (6). Digoxin's action is mostly indirect, and is mediated by an increase in vagal output to the AV node. In patients who are acutely ill or physically active, this vagal effect is often counteracted by high sympathetic tone, producing significant tachycardia and resistance to the effect of digitalis.

Coexisting conditions may help in selecting among the other rate-

TABLE 1. GOALS OF THERAPY

GOAL	POTENTIAL METHOD*	
IMPROVE SYMPTOMS	CONTROL VENTRICULAR RATE	RESTORE SINUS RHYTHM
IMPROVE HEMODYNAMICS		
PREVENT THROMBOEMBOLISM	ANTICOAGULATE	
PREVENT DEATH	AVOID ANTIARRHYTHMIC DRUGS?	

* Proof of desired result varies.

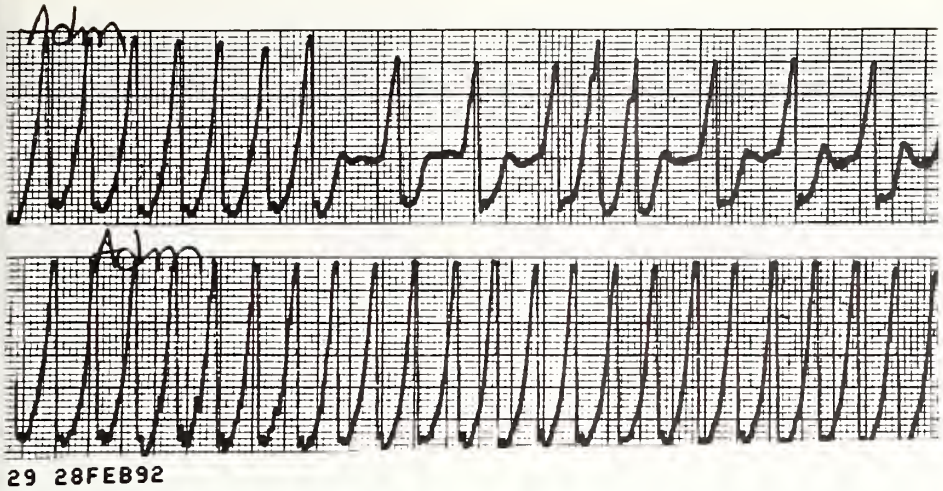


FIGURE 1. Atrial fibrillation in a patient with WPW syndrome. The two rhythm strips are not continuous. The key diagnostic finding is the irregularity of the wide-QRS rhythm, shown in the upper tracing. The rhythm in the lower tracing is regular, and in this segment it is indistinguishable from ventricular tachycardia. This patient was referred to us following treatment with digoxin and verapamil, which accelerated the ventricular rate.

TABLE 2. DRUGS FOR RATE CONTROL

DRUG	ROUTES	PARTICULARLY USEFUL	RELATIVELY CONTRAINDICATED
DIGOXIN	ORAL, IV	HEART FAILURE	RENAL FAILURE ACTIVE PT?
VERAPAMIL	ORAL, IV	ANGINA HYPERTENSION ACTIVE PT?	SEVERE HEART FAILURE
DILTIAZEM	ORAL, IV	ANGINA HYPERTENSION ACTIVE PT?	SEVERE HEART FAILURE
BETA-BLOCKERS	ORAL, IV	ANGINA HYPERTENSION POST-MI THYROTOXICOSIS	ASTHMA, SEVERE HEART FAILURE, DIABETES

IV = intravenous, MI = myocardial infarction, PT = patient.

controlling agents. For example, a beta-blocker might be an appropriate choice in a patient with prior myocardial infarction, based on the improved survival shown in trials of post-infarct beta-blocker therapy (7). However, as illustrated in Figure 1, *AV node blockade should be specifically avoided in patients with the WPW syndrome* since such efforts may accelerate the heart rate and lead to cardiovascular collapse and death. Most patients presenting with AF and WPW should be given early electrical cardioversion. In other patients, drug combinations for rate control may be helpful, as long as the physician takes into account the fact that verapamil will increase the serum level of digoxin (8).

Once the ventricular rate is controlled, consideration should be given to the potential risks and benefits of cardioversion to sinus rhythm. Pharmacologic or electrical cardioversion is feasible in most patients with AF, and we favor at least one attempt at conversion. Prolonged maintenance of sinus rhythm following conversion is less likely in patients who have been in AF a year or longer, or who have marked left atrial dilation, defined as a diameter of 6 cm. or more by echocardiography (9,10). Less marked atrial dilation does not greatly reduce the chance of success.

As shown in Table 2, restoration of sinus rhythm has many potential benefits. From the patient's standpoint, reduction of symptoms is generally the most important. The greatest risk of cardioversion is thromboembolism. Retrospective studies indicate that the acute risk of thromboembolism (approximately 3%) can be essentially eliminated by anticoagulation for three weeks before and after cardioversion (11).

The method of cardioversion (pharmacologic or electric) does not affect the risk of thromboembolism, and anticoagulation is therefore indicated with either technique. Some have advocated cardioversion without anticoagulation if transesophageal echocardiography is normal. We are aware of at least one reported case where this led to a cerebral embolus (12), and we do not support this as a routine approach in chronic AF.

If AF is known to have been present for less than 48 hours, the risk of thrombus formation is low, and such patients may be cardioverted without prior anticoagulation (13). Experience with one patient who suffered a stroke after a 12-hour episode of AF, and the frequent uncertainty in outpatients about the exact duration of AF lead us to favor acute anticoagulation in most elective cardioversions.

Rate-slowing drugs almost never restore sinus rhythm (14), and we usually begin therapy simultaneously with anticoagulant and rate-slowing medications. Concurrently, a work-up for underlying causes is initiated. At a minimum, this includes a 12-lead electrocardiogram, echocardiography, and thyroid function testing, in addition to a history and physical exam.

Available drugs which may restore sinus rhythm in AF patients include quinidine, procainamide, disopyramide, moricizine, flecainide, propafenone, sotalol, and amiodarone. A lengthy discussion of their relative merits is beyond the scope of this review, but several comments deserve mention. Except for amiodarone, all of these drugs carry a significant risk of inducing life-threatening ventricular tachycardia in 2% to 5% of patients. While practices vary, we are reluctant to initiate these drugs without one or more days of early in-hospital telemetric monitoring. Physicians

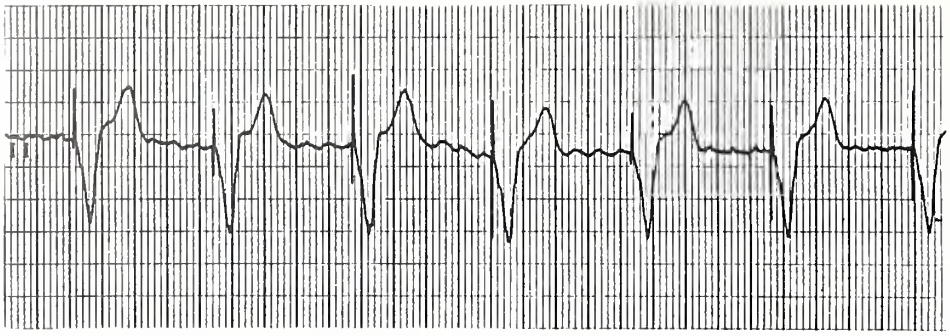


FIGURE 2. Control of ventricular rate following catheter ablation of the AV junction. Atrial fibrillation persists, and the ventricular rate is controlled by ventricular pacing.

using quinidine should be mindful of its interaction with digoxin, which can double or triple the serum digoxin level and produce serious toxicity.

The most effective drugs in restoring sinus rhythm are amiodarone and flecainide. Extrapolating from the CAST Study (Cardiac Arrhythmia Suppression Trial) (15), flecainide should be avoided in patients with impaired left ventricular function. In patients with normal ventricles, it can be used with efficacy and low risk, although cases of ventricular tachycardia have been reported (16). Flecainide is approved for treating AF, while amiodarone is not.

In almost all cases where we attempt elective conversion, we proceed to electrical cardioversion if one or two drugs fail to restore sinus rhythm. In adults, it is recommended to start at 200 joules, and increase subsequent shocks as necessary (11). These shocks should always be synchronized to reduce the risk of ventricular fibrillation. Patients with slow ventricular rates may be prone to bradycardia or asystole following cardioversion, and should be considered for prophylactic temporary pacing. Digoxin does not need to be stopped routinely prior to cardioversion, although cardioversion should be avoided in patients who are digitalis toxic.

The long-term efficacy of drugs in maintaining sinus rhythm following conversion is disappointing, and at best about 50%, even with amiodarone (17). Also, since two studies suggest increased mortality with chronic suppressive treatment of AF, there is a trend away from using such therapy, particularly in patients with reduced left ventricular function (18,19). This increased mortality is probably caused by drug-induced ventricular arrhythmias (a "proarrhythmic" response).

Amiodarone appears to have the lowest risk of serious proarrhythmia (< 1%), but it has not been widely used in the United States for treating AF, due to its other potential side effects, including hypothyroidism and pulmonary toxicity. Based on the European experience, wider use of amiodarone in AF appears justified, particularly if the maintenance dose (in adults) can be reduced to 300 mg./day. Serious toxicity at this dose is rare (20).

Patients in whom AF is not abolished remain at risk of thromboembolic events. There has been debate about the relative benefits of chronic anticoagulant treatment in patients with non-rheumatic AF. In the last several years, five randomized studies examining this issue have been published. All of these studies were stopped early since they showed a significant reduction in mortality among those treated by anticoagulants. Only modest degrees of anticoagulation suffice to reduce strokes, and at these levels (INR of about 1.5 to 2.5) (21), serious bleeding is uncommon.

We favor long-term mild anticoagulation in most older patients with AF. However, it should be recognized that many patients are unsuitable for such treatment, and were excluded from the randomized trials. In patients younger than 60 years with lone AF, the risk of stroke is so low that treatment with warfarin is unlikely to be of benefit, and is not routinely recommended. The role of aspirin as an alternative to warfarin remains controversial. We feel the available evidence presently favors use of warfarin in most patients in whom chronic anticoagulation is indicated.

New therapies

The final step in managing patients with AF is to consider whether they are candidates for any of the new non-pharmacologic therapies which are now available. Patients who cannot be maintained in sinus rhythm and who are refractory or intolerant to rate-controlling drugs should be considered for radiofrequency catheter ablation of the AV junction (22). This does not restore sinus rhythm, but allows control of the heart rate by ventricular pacing.

Figure 2 shows the electrocardiogram of the first patient we treated with this technique, in conjunction with implantation of a permanent pacemaker. Substantial improvement in symptoms and in ventricular function was achieved. Others have observed similar improvement in ventricular function in patients treated by catheter ablation (23).

Other non-pharmacologic treatments under study include direct surgical intervention (maze procedure) (24), and use of internal cardioversion where transthoracic cardioversion has not been successful (25). The maze procedure involves an extensive series of incisions in the right and left atria, which are designed to create anatomic obstacles to the reentrant circuits which underlie AF. The procedure is complex, but has been very successful in restoring sinus rhythm in selected patients. Preferred candidates for the maze procedure are otherwise healthy individuals who are highly symptomatic from chronic AF in spite of medical therapy, and those who remain symptomatic in spite of successful catheter ablation.

The role of internal cardioversion is still under investigation. High energy (200 or 300 joules) internal shocks delivered through conventional electrode catheters have been reported to restore sinus rhythm when external shocks (300 or 360 joules) were unsuccessful. In our experience, achieving external electrical conversion with adequate energy settings is much less of a problem than maintaining sinus rhythm once AF has been terminated. In the study of internal cardioversion of Lévy and colleagues, only 37% of patients who were successfully cardioverted remained in sinus rhythm at one year, in spite of maintenance therapy with amiodarone 200 mg./day (22).

There is interest in developing methods of low-energy internal defibrillation as a chronic treatment for AF, but these techniques remain highly experimental. Implantable defibrillators used in the conventional manner do not reliably terminate AF, and in fact they may induce the arrhythmia in patients who did not previously have this condition. This

can lead to serious problems since the defibrillator may mistake the fast rate of AF for ventricular tachycardia, which results in frequent inappropriate shocks.

Summary

AF remains a common and frequently troubling arrhythmia for which available therapies have limitations. Based on data from recent clinical trials, there has been a trend away from routine use of chronic antiarrhythmic drugs toward greater use of low-dose anticoagulant therapy.

Once considered a relatively static topic, it is likely that our approach to AF will continue to evolve as results of further research become available.

References

1. Kannel WB, Wolf PA. Epidemiology of atrial fibrillation. In: Falk RH, Podrid PJ, editors. Atrial fibrillation: mechanisms and management. New York: Raven Press, 1992,81-92.
2. The Boston Area Anticoagulation Trial for Atrial Fibrillation Investigators. The effect of low-dose warfarin on the risk of stroke in patients with nonrheumatic atrial fibrillation. N Engl J Med 1990;323:1505-11.
3. Brand FN, Abbott RD, Kannel WB, Wolf PA. Characteristics and prognosis of lone atrial fibrillation. Thirty year follow-up in the Framingham study. JAMA 1985;254:3449-53.
4. Kopecky SL, Gersh BJ, McGoon MD, Whisnant JP, Holmes DR Jr, Ilstrup DM, et al. The natural history of lone atrial fibrillation: a population-based study over three decades. N Engl J Med 1987;317:669-74.
5. Petersen P, Godtfredsen J. Embolic complications in paroxysmal atrial fibrillation. Stroke 1986;17:622-26.
6. Falk RH, Leavitt JI. Digoxin for atrial fibrillation: a drug whose time has gone? Ann Intern Med 1991;14:573-5.
7. Yusuf S, Peto R, Lewis J, Collins, Sleight P. Beta blockade during and after myocardial infarction: an overview of randomized trials. Prog Cardiovasc Dis 1985;27:335-71.
8. Panidis LP, Morganroth J, Baessler C. Effectiveness and safety of oral verapamil to control exercise-induced tachycardia in patients with atrial fibrillation receiving digitalis. Am J Cardiol 1983;52:1197-1201.
9. Dittrich HC, Erickson JS, Schneiderman T, Blacky AR, Savides T, Nicod PH. Echocardiographic and clinical predictors for outcome of elective cardioversion of atrial fibrillation. Am J Cardiol 1989;63:193-7.
10. Brodsky MA, Allen BJ, Capparelli EV, Luckett CR, Morton R, Henry WL. Factors determining maintenance of sinus rhythm after chronic atrial fibrillation with left atrial dilatation. Am J Cardiol 1989;63:1065-8.
11. Arnold AZ, Mick MJ, Mazurek RP, Loop FD, Trohman RG. Role of prophylactic anticoagulation for direct current cardioversion in patients with atrial fibrillation or atrial flutter. J Am Coll Cardiol 1992;19:851-5.
12. Ewy GA. Optimal technique for electrical cardioversion of atrial fibrillation [editorial]. Circulation 1992,86:1645-7.
13. Pritchett ELC. Management of atrial fibrillation. N Engl J Med 1992;326:1264-71.
14. Falk RH, Knowlton AA, Bernard SA, Gotlieb NE, Battinelli NJ. Digoxin for converting recent-onset atrial fibrillation to sinus rhythm. A randomized, double-blinded trial. Ann Intern Med 1987;106:503-6.
15. Echt DS, Liebson PR, Mitchell LB, Peters RW, Obias-Manno D, Barker AH, et al. Mortality and morbidity in patients receiving encainide, flecainide, or placebo. The Cardiac Arrhythmia Suppression Trial. N Engl J Med 1991;324:781-8.
16. Falk RH. Flecainide-induced ventricular tachycardia and fibrillation in patients treated for atrial fibrillation. Ann Intern Med 1989;111:107-11.
17. Fuchs T, Podrid PJ. Pharmocologic therapy for reversion of atrial fibrillation and maintenance of sinus rhythm. In: Falk RH, Podrid PJ, editors. Atrial fibrillation: mechanisms and management. New York: Raven Press, 1992,233-54.
18. Coplen SE, Antman EM, Berlin JA, Hewitt P, Chalmers TC. Efficacy and safety of quinidine therapy for maintenance of sinus rhythm after cardioversion. A meta analysis of randomized control trials. Circulation 1990;82:1106-16.
19. Flaker GC, Blackshear JL, McBride R, Kronmal RA, Halperin JL, Hart RG. Antiarrhythmic drug therapy and cardiac mortality in atrial fibrillation. J Am Coll Cardio 1992;20:527-32.
20. Dusman RE, Stanton MS, Miles WM, Klein LS, Zipes DP, Fineberg NS, et al. Clinical features of amiodarone-induced pulmonary toxicity. Circulation 1990;82:51-9.
21. Hirsh J. Oral anticoagulant drugs. N Engl J Med 1991;324:1865-75.
22. Scheinman MM, Laks MM, DiMarco J, Plumb V. Current role of catheter ablative procedures in patients with cardiac arrhythmias: A report for health professionals from the subcommittee on electrocardiography and electrophysiology, American Heart Association. Circulation 1991;83:2146-53.
23. Heinz G, Siostrzonek P, Kreiner G, Gossinger H. Improvement in left ventricular systolic function after successful radiofrequency His bundle ablation for drug refractory, chronic atrial fibrillation and recurrent atrial flutter. Am J Cardiol 1992;69:489-92.
24. Cox JL, Boineau JP, Lindsay BD, Cain ME, Corr PB, Kater KM, Lappas DG. A review of surgery for atrial fibrillation. J Cardiovasc Electrophysiol 1991;2:541-61.
25. Levy S, Lauribe P, Dolla E, Kou W, Kadish A, Calkins H, et al. A randomized comparison of external and internal cardioversion of chronic atrial fibrillation. Circulation 1992;86:1415-20.

Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Giant posterior inferior cerebellar artery aneurysm associated with foramen magnum syndrome

BRYAN K. RICHMOND, M.D.
Department of Surgery, Robert C. Byrd Health Sciences Center and Charleston Area Medical Center, Charleston

JOHN H. SCHMIDT III, M.D., F.A.C.S.
Clinical Assistant Professor of Neurosurgery, Robert C. Byrd Health Sciences Center and Charleston Area Medical Center, Charleston

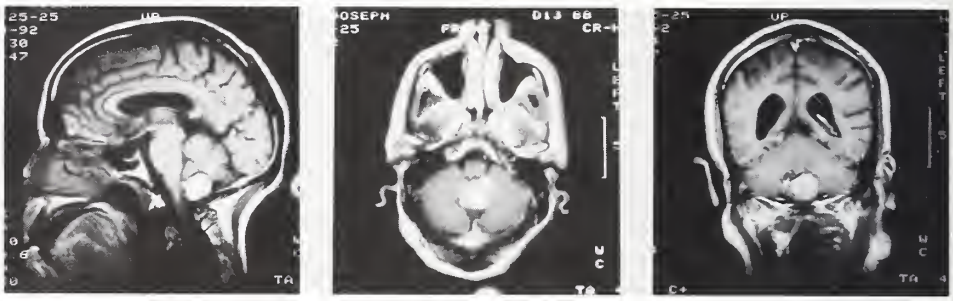


Figure 1. MRI of the brain showing mass lesion located posteriorly at the inferior vermis of the cerebellum.

Abstract

The case of a giant distal posterior inferior cerebellar artery (PICA) aneurysm which caused foramen magnum syndrome is presented. A 67-year-old male was referred for evaluation of a posterior fossa mass lesion on MRI scan. Craniotomy was performed which revealed a giant and completely thrombosed aneurysm of the distal PICA, which was subsequently excised intact. This report adds giant aneurysm of the PICA to the list of posterior fossa lesions reported which cause foramen magnum syndrome.

Introduction

Compression of the brainstem at the level of the foramen magnum results in a myriad of signs and symptoms known as foramen magnum syndrome. The clinical picture consists of cervico-occipital pain, weakness and paresthesias of the extremities, atrophy of the intrinsic hand muscles, impaired proprioception and vibratory sense greatest in the upper extremities and a paucity of lower cranial nerve findings (1,3,5,7,10,11,12).

This complex and somewhat variable presentation has often resulted in an incorrect diagnosis, usually multiple sclerosis (1,3,7), but tumors are the most common cause of foramen magnum syndrome (7). Giant aneurysms frequently present with compression of adjacent structures and have also been reported to cause compression at the level of the foramen magnum. However, these giant aneurysms have been confined to the vertebral artery (4,8,9).

This case illustrates the only known case of a giant distal PICA aneurysm causing foramen magnum syndrome.

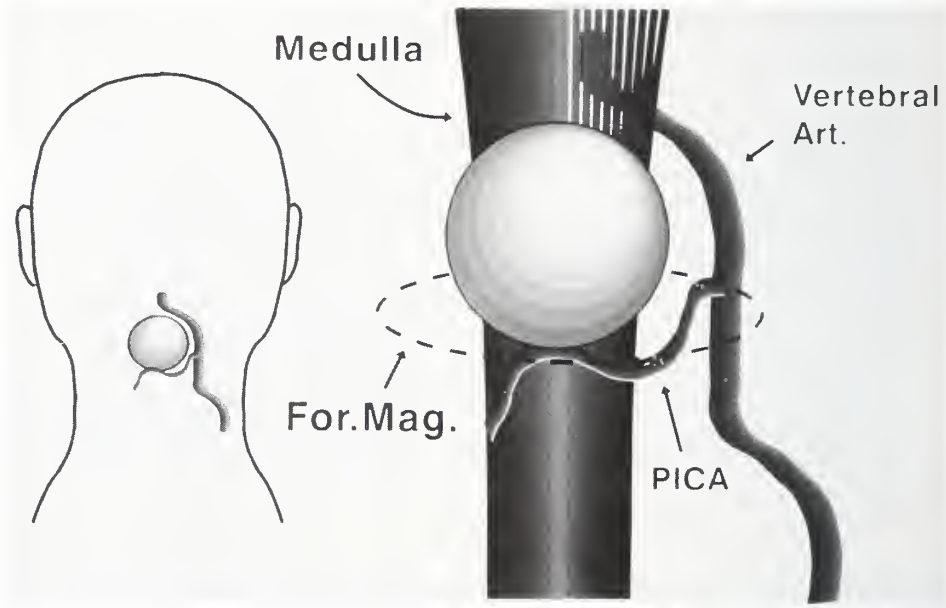


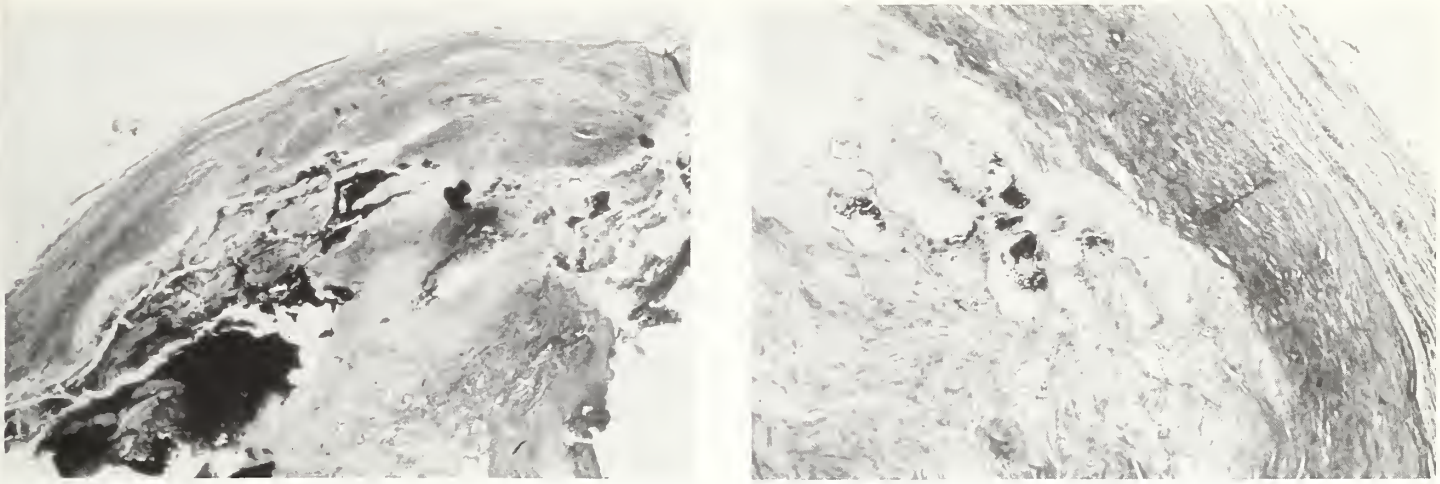
Figure 2. Artist's rendition illustrating the location of the aneurysm and the course of the PICA in relation to the foramen magnum.

Case report

A 67-year-old-man with a history of a slowly evolving quadraparesis over a 30-year period became a patient at a rehabilitation service after suffering a myocardial infarction. Early in his clinical course, this patient had undergone myelography which revealed a high cervical block. Subsequently, he received a course of radiation treatment to this region for a suspected spinal cord tumor, showed no improvement, and was diagnosed as having multiple sclerosis.

The man's mental status and level of consciousness was normal, and cranial nerve examination was grossly intact with the exception of a torticollis with head to the right. Spastic quadraparesis was present, with marked hyperreflexia and bilateral Babinski signs. Sensory examination revealed impairment of proprioception and loss of vibratory sense in all extremities with sparing of pin-prick sensation.

In view of this patient's complex constellation of neurological signs, an MRI of the brain and cervical spine was obtained which revealed a 2.5 cm. mass at the inferior vermis of the cerebellum extending to the floor of the fourth ventricle (Figure 1). No lesions consistent with MS were noted. Midline posteria fossa craniotomy was performed and exploration of the



A: Trichrome x 4 B: Trichrome x 15.5

Figure 3. Photomicrographs showing wall of aneurysm with partially recanalized intraluminal thrombus.

region revealed that the mass arose from the right distal PICA (Figure 2).

The mass was opened and found to contain organized thrombus, consistent with a giant aneurysm. It was subsequently excised intact although flow remained absent in the PICA. The microscopic findings were consistent with giant intracranial aneurysm (Figure 3).

Discussion

Foramen magnum syndrome remains difficult to diagnose. Cervico-occipital pain is the most consistent complain, followed by paresthesias or dysesthesia involving the upper extremities. Gait disturbance is also frequently present (1,3,5,7,10,11,12).

Weakness and spasticity first appear in the ipsilateral upper extremity, and are soon followed by subjective and objective sensory disturbances in the same limb. As weakness and spasticity appear in the other limbs, they are reported to do so in a regular sequence, first affecting the ipsilateral lower limb, then the contralateral lower limb and finally the contralateral upper limb (5,11).

Wasting of the intrinsic hand muscles is also common (3,7,10,11), as well as loss of proprioception and vibratory sense, with the upper extremities affected disproportionately compared to the lower extremities (2). In addition, nystagmus has been less frequently reported and is most common with lesions arising from or located primarily in the posterior fossa (7,10,11). Cranial nerve XI is the nerve most usually involved (7,10,11).

Tumors in the region of the foramen magnum are the most common cause of foramen magnum syndrome and most of these are meningiomas followed by neurofibromas. Other tumors which are found less commonly include dermoid cysts, lipomas, chordomas and hemangioblastomas (1,3,5,7,10,11).

Giant aneurysms of the vertebrobasilar circulation have been reported to cause symptoms related to posterior fossa mass effect and have been misdiagnosed as tumors (4,7,8). However, giant vertebral artery aneurysms are the only aneurysms of the posterior circulation that have been previously reported to cause foramen magnum syndrome (3,8,9,11). Alexander and colleagues reported one case of a giant PICA aneurysm that presented with hydrocephalus and signs of increased intracranial pressure secondary to obstruction of the fourth ventricle (2). This patient, though, presented with a normal motor and sensory examination, findings which are inconsistent with foramen magnum syndrome.

MRI scan often characterizes giant aneurysms better than CT or angiography and is useful in detecting not only the exact size of the lesion, but also the amount of intraluminal thrombus and the degree of flow in the parent artery (6). A flow void was not noted in this case because both the aneurysm and artery were completely thrombosed, which we believe demonstrates a shortcoming of MRI. Angiography was not performed since aneurysm was not suspected, but would have been unyielding due to the extensive thrombosis of the PICA and the aneurysm.

Ultimately, a high index of suspicion leading to early and correct diagnosis provides the greatest opportunity for a good outcome.

References

1. Abbott KH. Foramen magnum and high cervical cord lesions simulating degenerative diseases of the nervous system. Ohio St Med J 1950;46:645-51.
2. Alexander E Jr, David CH, Pikula L. Aneurysm of the posterior inferior cerebellar artery filling the fourth ventricle. J Neurosurg 1966;24:99-101.
3. Alexander GL. Foramen magnum and high cervical syndromes. Scott Med J 1958;3:329-40.
4. Bull J. Massive aneurysms at the base of the brain. Brian 1969;92:535-70.
5. Cohen L, Macrae D. Tumors in the region of the foramen magnum. J Neurosurg 1962; 19:462-9.
6. Human RA, Black KS. Aneurysms and vascular malformations. Top Magn Reson Imaging 1989;2:49-623.
7. Meger FB, Ebersold MJ, Reese DF. Benign tumors of the foramen magnum. J Neurosurg 1984;61:136-42.
8. Michael WF. Posterior fossa aneurysms simulating tumors. J Neurol Neurosurg Psychiatry 1974;37:218-23.
9. Sorensen P, Lundorf E. Giant aneurysm of the vertebral artery simulating intracranial tumor at the foramen magnum. Neuroradiology 1988;30:359.
10. Stein BM, Leeds NE, Traveras JM, Pool JL. Meningiomas of the foramen magnum. J Neurosurg 1963;20:740-51.
11. Symonds CP, Meadows SP. Compression of the spinal cord in the region of the foramen magnum. Brain 1937:60:52-84.
12. Taylor AR, Byrnes DP. Foramen magnum and high cervical cord compression. Brain 1974;97:473-80.

The gynecologist and treatment of carcinoma of the breast

CURTIS D. WHITE, M.D.
Department of Obstetrics and Gynecology, Marietta Memorial Hospital, Marietta, Ohio.

Abstract

The treatment of breast carcinoma has traditionally been relegated to the general surgeon. The gynecologist, in his/her role of treating women's diseases, will likely become more involved in the future. This article describes the experience of one gynecologist in the treatment of carcinoma of the breast involving 234 biopsies which were performed from January 1985 to December 1992. Invasive carcinoma was found in 81 of the cases, and five showed in situ carcinoma.

Introduction

For more than half a century after Halstead published his original work, the true radical mastectomy was the standard treatment for carcinoma of the breast (1). Efforts to improve cosmesis and decrease morbidity without compromising cure led to the introduction of the modified radical mastectomy (2).

Now, with improved patient education, self-breast exams, and especially the increasing use of mammography, breast cancers are being detected much earlier. This has led to increasing interest in more limited, less disfiguring surgical treatment. Many studies have demonstrated comparable cure by removing just the neoplastic area (wide excision or "lumpectomy") followed by radiation therapy (3-7). Removal of the axillary lymph nodes, which was once felt to be a necessary part of surgical treatment, has become more of a diagnostic measure. However, the status of the axillary lymph nodes are useful in deciding upon adjuvant therapy.

Traditionally, the surgical management of cancer of the breast has been the domain of the general surgeon (8). Since many women look to their gynecologist as their primary care physician and examination of the breast is part of their standard exam, the gynecologist's involvement in the treatment of cancer of the breast has increased significantly.

The purpose of this review is to present one gynecologist's experience in the treatment of cancer of the breast.

Materials and methods

From January 1985 to December 1992, 234 patients in my group practice underwent biopsy of the breast. The usual reason was for a new or suspicious lesion detected by examination and/or mammography, although in some cases patient anxiety was a factor.

All patients in the study prior to December 1990 had mammograms before their biopsies. The majority of these mammograms were performed at Marietta Memorial Hospital in Marietta, Ohio, using xeromammography, although some patients chose other local hospitals. After December 1990, most mammograms were performed in our office using a GE Senographe 600T Filmscreen mammography machine. A total of 1,143 mammograms were performed in our office in 1991 and 1,153 were performed in 1992.

All biopsies were done on an outpatient basis and generally were performed under local anesthesia with additional I.V. sedation as needed. Frozen sections were performed in a room next to the operating suite allowing direct communication between myself and the pathologist and even a chance to view the slides, as needed. This interaction prior to completion of the biopsy made it possible to resect additional margins at that time if there were any concerns about the adequacy of the resection. Patients were informed, prior to leaving the hospital, of the frozen section diagnosis but, with only two exceptions, definitive surgery was delayed until final permanent sections were available.

Options of therapy were discussed with the patient and her family prior to leaving the hospital. Patients were usually seen in the office within one week to again review the diagnosis and discuss options of therapy.

Patients with stages I and II lesions, which were less than four centimeters in size and did not show evidence of multifocal disease, were generally given an unbiased discussion of breast conservation versus modified radical mastectomy. Reconstruction was also discussed at that time.

In those patients choosing breast conservation, an axillary dissection was subsequently performed through an approximately five centimeter curvilinear axillary incision and usually placed in a skin fold for cosmesis. All patients were given 2 grams of Keflin I.V. intraoperatively as prophylaxis. Lymph nodes were routinely dissected from level I and II and only rarely from level III.

After approximately two weeks for wound healing, patients were referred for radiation therapy. Treatment generally consisted of 5,000 cGy tangentially to the breast given over five weeks in 25 fractions at 200 cGy/d five days a week. Treatment planning was guided by CT with computer-aided dosimetry. If the axillary nodes were negative, the supraclavicular nodes were not irradiated. Following a two-week rest period, the original tumor bed was again boosted with an 1,500 cGy from electrons at various depths or with ^{192}iridium needle implants for deeper lesions. The decision for adjuvant chemotherapy or hormonal therapy was based upon a number of factors and will not be reviewed.

In those patients choosing breast removal, a modified radical mastectomy was performed usually using a Stewart incision to remove the breast along with the pectoralis fascia, level I and level II lymph nodes, but rarely level III.

Results

Of the 234 patients undergoing breast biopsy, 81 showed invasive carcinoma and five in situ carcinoma. Of the 81 invasive lesions, 36 (44%) were treated with modified radical mastectomy (MRM) and 45 (55%) by "lumpectomy" with axillary dissection (Table 1).

TABLE 1. Distribution of Patients Treated for Invasive Carcinoma

36	(44.4%) Modified Radical Mastectomy
45	(55.6%) Lumpectomy with Axillary Dissection
81	Total

TABLE 2. Average Number of Lymph Nodes Removed From Level I and Level II

Patients Undergoing Mastectomy	
Level I	6.4 Nodes
Level II	5.7 Nodes
Patients Undergoing Breast Conservation with Axillary Dissection	
Level I	7.4 Nodes
Level II	5.8 Nodes

TABLE 3. Percentage of Patients with Positive Lymph Nodes

Modified Radical Mastectomy	9 of 36 (25%)
Breast Conservation with Axillary Dissection	14 of 45 (31.1%)

The average age of the women with invasive carcinoma was 56.3 years, while the average age of women with in situ carcinoma was 41.7 years. The women who choose to undergo breast conservation were an average age of 53.4 years; and those undergoing mastectomy were an average age of 60 years.

Of the 36 undergoing MRM, five did so because the lesion was greater than or equal to 4.5 centimeters. In an additional four cases, there were multiple fixed axillary nodes, in addition to a large primary. The remaining 31, all stages I and II, chose mastectomy over breast conservation.

The number of lymph nodes removed in the patients who had mastectomies is listed in Table 2. There was an average of 6.4 nodes removed from level I and 5.7 from level II. Of those undergoing breast conservation with axillary dissection, there was an average of 7.4 nodes removed from level I and 5.8 from level II.

The women whose nodes were positive were an average age of 51.1 years (range 33-90). Nine of these 36 women (25%) who underwent MRM had positive nodes with an average of three (range 2-6). Of the 45 patients undergoing breast conservation and axillary dissection, 14 (31%) had positive lymph nodes. The average age of these women was 55.8 years, with an average of 4.7 nodes positive (range 1-14) (Table 3).

Fourteen (17%) of the 81 patients with invasive carcinoma developed recurrence with follow-up of one to six years. Two of these women developed a new primary in the opposite breast, and one developed a new lesion in another quadrant of the breast previously treated by lumpectomy and radiation therapy. These three patients previously had negative lymph nodes.

Of the remaining 11 patients with metastatic recurrences, 9 (82%) were in patients who previously had positive lymph nodes. Six of these nine had positive estrogen receptors. The two with negative nodes and recurrences were both receptor positive.

Discussion

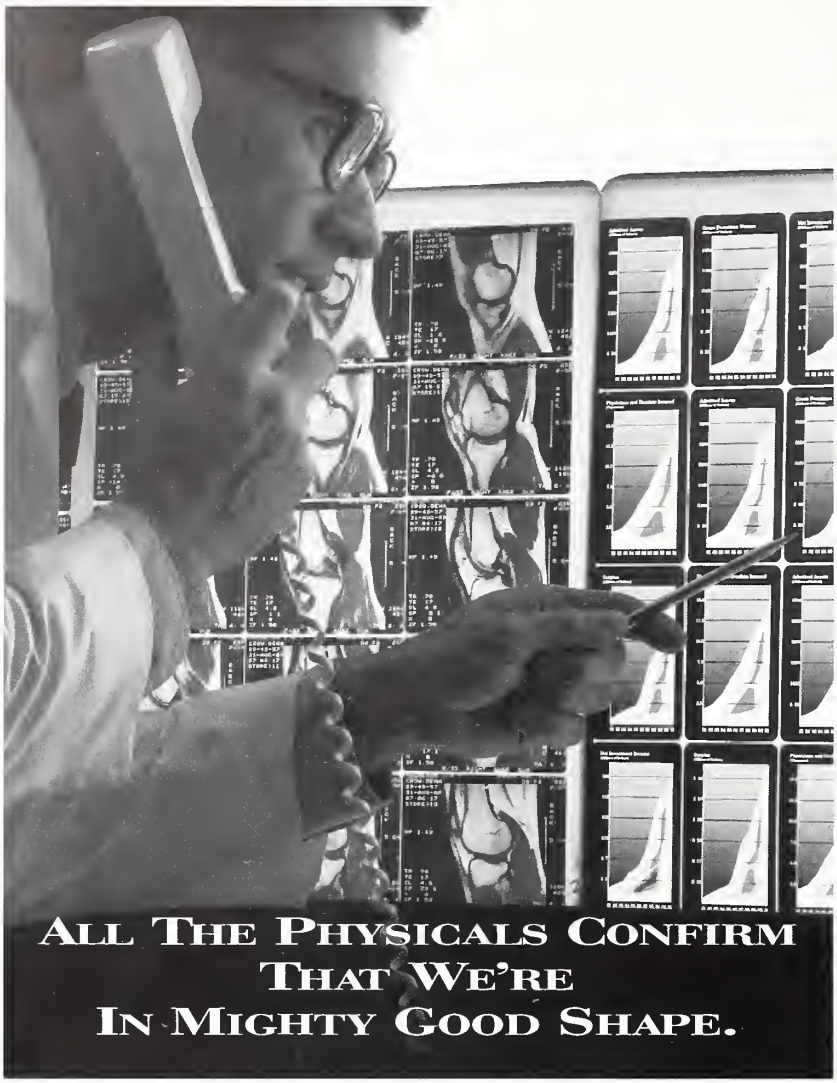
There is still debate about the optimal method of treatment of breast carcinoma. Despite ample evidence suggesting that breast conservation (wide excision, axillary lymph node dissection, radiation therapy) offers equal cure compared with MRM, many still favor the more radical approach (4). Physicians' biases may have a profound effect on the patient's choice for treatment.

The role of the gynecologist in the treatment of diseases of the breast remains controversial. Despite the fact that many women look to their gynecologist for breast examination, the surgical treatment of the breast has generally been relegated to the general surgeon (8).

I conclude that in the future, gynecologists will be more involved in the treatment of diseases of the breast. Increasing use of in-office needle biopsies and the introduction of sterotactic needle biopsies will decrease the number of hospital surgical biopsies.

References

1. Halstead WS. The treatment of wounds with special reference to the value of blood clots in the management of dead spaces. Johns Hopkins Hosp Rep 1990-1991;2:255.
2. Patey DH. Review of 146 cases of carcinoma of the breast operated on between 1930 and 1943. Br J Cancer 1967;21:260.
3. Fischer B, Bauer M, Magolose R, et al. Five-year results of a randomized clinical trial comparing total mastectomy and segmental mastectomy with or without radiation in the treatment of breast cancer. N Engl J Med 1985;312:665.
4. Fisher B, Redmond C, Fisher ER, et al. Ten-year results of a randomized trial comparing radical mastectomy and total mastectomy with or without radiation. N Engl Med 1985; 312:674.
5. Veronesi U, Saccozzi R, Del Vecchio M, et al. Comparing radical mastectomy with quadrantectomy, axillary dissection, and radiotherapy in patients with small cancers of one breast. N Engl J Med 1981;305:6.
6. Adkins H, Hayward JL, Klugman DJ, et al. Treatment of early breast cancer: A report after ten years of clinical trial. Br Med J 1972;2:423.
7. Lichter AS. Current status of primary breast cancer treatment with local excision plus radiation. Curr Concepts Oncol 1983;5:17.
8. Hayward J. The surgeon's role in primary breast cancer. Breast Cancer Res Treat 1981; 1:27.
9. White, CD. The gynecologist's role in the treatment of breast carcinoma. J Reprod Med 1990;35:232.

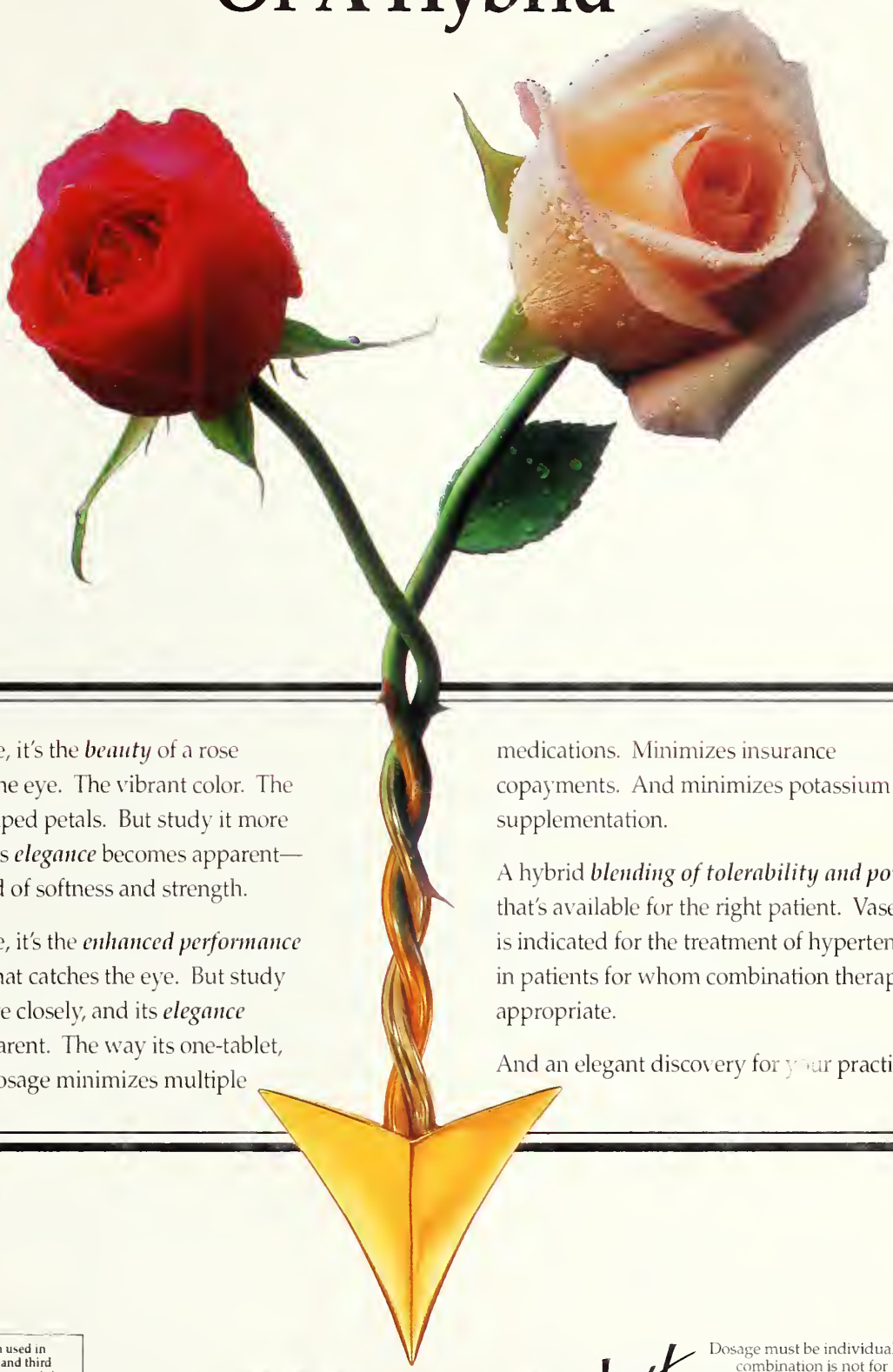


Examine our performance and you'll agree. Membership was up again last year, passing 15,000. Total premiums written surpassed $150 million. Policyholders' surplus of nearly $50 million. Healthy numbers, confirmed by insurance auditors, and an A.M. Best Rating of B+(Very Good). We have a strong financial position, increasing market share and competitive pricing. A solid foundation for your future. For more information, call us at 1-800-228-2335.

THE P•I•E MUTUAL INSURANCE COMPANY

North Point Tower
1001 Lakeside Avenue
Cleveland, Ohio 44114
800-228-2335

Discover The Elegance Of A Hybrid



At first glance, it's the *beauty* of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its *elegance* becomes apparent—a gentle blend of softness and strength.

At first glance, it's the *enhanced performance* of Vaseretic that catches the eye. But study Vaseretic more closely, and its *elegance* becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid *blending of tolerability and power* that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

VASERETIC® 10-25 *Next*
Enalapril Maleate-Hydrochlorothiazide

Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

TABLETS
VASERETIC®
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)

10 mg **25 mg**

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General; Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions,* and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide).*

Pregnancy: Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality,* below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General; Enalapril Maleate; Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions.)*

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium).*

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients: Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions: Enalapril Maleate; Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide; When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

* Registered trademark of Hospal Ltd.

Vaseretic® is a registered trademark of Merck & Co., Inc.

Manufactured by Merck & Co., Inc.

© 1993 DuPont Pharma

Printed in USA

bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 μg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy; Pregnancy Categories C (first trimester) *and* D (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other:* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough.*

Clinical Laboratory Test Findings; Serum Electrolytes: See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular:* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established. *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses:* Transient blurred vision, xanthopsia.

* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

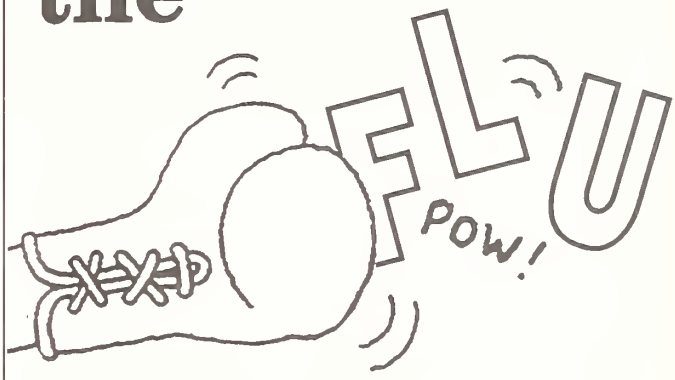
Dist. by

MERCK & CO., INC.
West Point, PA 19486, USA

Issued June 1993
7432318

Printed in USA

Be a fighter. Knock out the



before the Flu knocks you!

Get a flu shot!

Speak to your doctor or local health department.

Your contribution to Christmas Seals® makes this program possible.

AMERICAN LUNG ASSOCIATION®

Space contributed by the publisher as a public service.

President's Page

James L Comeri M.D.

WVSMA advocates change

Your Legislative Committee has been meeting over the last six to eight weeks to develop potential legislation to be introduced during the 1994 session of the West Virginia Legislature. The principal points proposed by the Legislative Committee were adopted by Council at their November 14 meeting, and these philosophies will be used to formulate WVSMA policy as the debate over health reform moves forward during the next few months.

In addition, these principles will be expanded into a legislative program entitled **"PATIENT POWER"** which will be detailed in an upcoming White Paper published by the WVSMA. A draft of **PATIENT POWER** begins below and I hope you will please take the time to read, comment and communicate these concepts to your colleagues and your patients. I also encourage you to be familiar with other plans being introduced.

PATIENT POWER

The doctors of the West Virginia State Medical Association are, like many citizens, concerned about the future of health care in the United States and in West Virginia. Although the people of our country and our state enjoy the benefits of the world's best medical care, we do have some problems concerning cost and access. Our challenge is to deal with these problems while maintaining the most salient feature of American medical care — the kind of quality that draws heads of state and other world leaders to our shores for treatment of their serious health problems.

We believe that a careful restructuring of the system rather than complete change will accomplish the goals of universal access, cost savings, and quality, as well as preserve freedom of choice without an increase in government intervention. Our plan promotes the concepts of personal medical savings accounts, catastrophic health insurance, tax credits and vouchers to allow government to help those who need it, health insurance reform to prevent cancellations and allow portability, small group insurance co-ops and individual choice.

The doctors of the West Virginia State Medical Association look forward to working with you, patients we serve, and with government leaders in a cooperative spirit necessary for the solutions to our health care problems. We can accomplish this by employing the concepts which have always been the strength of America and of West Virginia — individual freedom and responsibility; a free market for goods, services, and ideas; a robust competitive environment; and government involvement designed to protect those who cannot fully care for their own needs.

In addition to presenting **PATIENT POWER** to you this month, I want to also update you on Council's positions on the following issues:

1. **State/Federal Health Boards** - We do not believe that the development of state and federal health boards is necessary. We feel this would add another layer of bureaucracy when government agencies and administrators already have the responsibility to carry out the duties that would be assigned to the boards. We would not support establishment of a board given power to set rates, cap fees, establish mandated benefits or dictate network structure. An advisory committee with provider input may be a reasonable alternative.
2. **Networks** - Many health care delivery networks are already in existence and new ones are forming each day. We should encourage and not mandate this development and make sure they form on a level playing field. Government intervention should be limited to leveling that field and reducing or eliminating anti-trust regulations. Close attention should be paid to networks already in existence.
3. **Nurse Practitioners, Physicians Assistants and Nurse Midwives** - These individuals are an important part of the health care team and should continue to function as part of that team in collaborative agreements with physicians.

Another important action which the Council took during their meeting, was the acceptance of a proposal from the WVSMA's Legislative Committee to design legislation supporting a medical savings account. The Legislative Committee has been researching various health system reform plans for the past few months. Last year, the committee endorsed and the WVSMA introduced the Basic Health Care For Employees Act during the Legislature's 1993 session, which mandated employers provide health coverage. The committee recently agreed that with the economic conditions in the state such a mandate would not now be feasible.

With this philosophy in mind, the Council has adopted the Legislative Committee's recommendation and will be incorporating the following principles into any legislation that is proposed:

The WVSMA advocates market-based solutions to our health care problems, including but not limited to such things as:

- personal medical savings accounts coupled with high-deductible catastrophic health insurance
- tax credits, vouchers, and subsidies as required to facilitate the above
- changes in the tax laws to level the playing field and treat equally all who purchase health insurance
- meaningful tort reform
- insurance reform in such areas as cancellation, portability, administrative efficiency, etc.
- small group insurance cooperatives and government incentives to employers to offer health insurance
- the encouragement of price competition in health care to decrease costs through market forces

and that we disagree with the following concepts on a national and state level

- global health budgets
- fee and/or premium caps
- a National (or State) Health Board
- monopolistic health alliances that may restrict competition
- employer mandates for health insurance coverages
- mandated standard benefit packages
- mandated managed care and/or gatekeeper systems.

– James L. Comerci, M.D.

A Dollar A Day

will help things go your way!

$365 Club

WESPAC has a new club - the $365 Club - or A Dollar A Day. Just think about it, a dollar a day can better help reform the health care system and protect your rights as physicians as well as the rights of your patients. Don't wait, the time to act is now!! **Send your personal check to WESPAC and become involved!**

WESPAC
P.O. Box 4106
Charleston, WV 25364

The split in Medicine

We have heard and read much recently about the "split" which has occurred in the ranks of Medicine over health care reform measures currently before Congress. It is suggested that the Clinton administration will take advantage of the split to ramrod its plan through a Congress seemingly confused and intimidated by the possibility its members could alienate the feminist vote by tilting with Hillary. The Byzantine pathways of our legislative process are once again revealed in all their shameful irrelevancy.

But what about this split in Medicine's ranks? Doctors disagreeing with each other? Unheard of, you say? Jim Todd, executive vice president of the American Medical Association, says that getting consensus among any group of doctors is like trying to herd a bunch of cats. Anyone who has ever attended a medical meeting of any size knows, of course, that he is right.

Yes, we have many doctors intent on being as Politically Correct as their yuppie neighbors and we have our rednecks. We have had our town and gown groups, our academics, and the toilers in the field. Those with the most ready access to a microphone may be the first to express opinions on television but frequently turn out to be a noticed but definite minority.

Medical opinion on medical reform will evolve. How could anyone express an opinion on anything as amorphous as an idea that takes 1,300+ pages of typed script to explain? Who, besides perhaps Ira Magaziner, Hillary's health care guru, has ever read those 1,300+ pages describing Hillary's plan? Who will volunteer to read them? Who in this world is capable of understanding any 1,300+ pages of legalese thrown together by a platoon or two of hack lawyer legislative writers?

So, we need to argue about this some more, chew it up, masticate it well and then spit it out. Is there anyone out there without some idea or opinion about how Medicine might be improved? To espouse some such reform issue does not necessarily put one in conflict with another or a group of others with another reform idea. Nor does agreeing with some part of Hillary's plan make one a supporter of her plan.

As physicians, we need to reflect on and keep in mind the tactical political game Medicine has been playing with legislators on state and federal levels since at least the 1940s during the Truman administration. The first serious proposals were made then to establish a government funded and controlled system of medical care. Each such succeeding proposal, including the present one, has contained a problem crucial to every politician required to vote on it -- who will be the rationer? There has never been the least question in any of these proposals, including Hillary's, that rationing of medical care will be necessary. Medicine has consistently declined the role of rationer for its members and should continue to do so.

Anyone who has run for an elective office can understand why it is important that doctors not surrender on the issue of who is to be the rationer. People get angry when denied anything they want. They will not vote for office seekers responsible for their wants; they will resent doctors who obviously and overtly deny them care. A day at the office is difficult enough without having one patient after another resent you, question your dedication, and be suspicious of your intentions.

Under the fee for service system, the doctor is the agent for the patient and responsible for getting the very best care and attention available in the field of medicine for that patient. Looking through the murk of Hillary's plan, one thing that seems perfectly clear is that the individual physician, ensconded in a very competitive group, is the one once again wearing the black hat.

That very competitive group will remain in business only as long as it bullies its doctors into giving less care than they would otherwise be inclined to give. Physicians currently involved in HMO-style care know the story -- the story of monetary limits placed on the sum of medical care for an individual, or worse, the sum of all the care doled out to an HMO list, holding hostage significant percentages of fees (withholding) held to be allowable, and fines for exceeding limits on retrospectively denied care.

It should not be a requirement for the privilege of practicing medicine that we must be willing to cheat our patients out of care promised to them by others and which, in their innocence, they believe they will get.

With one another we can argue, dispute, declaim and criticize in our usual way, about an endless list of subjects in Medicine, the organization of Medicine and the fiscal policies concerning Medicine. We can split and display our individuality, our independence and our capacity for innovation on any number of other subjects, but we dare not be split on the subject of whose side we choose to be on -- our patients or some fund of money. If our loyalties waver in that regard, the practice of Medicine will not long hold attraction for anyone presently held worthy of the title Doctor.

— SDW

In My Opinion

Clinton plan unnecessarily complex

As health care reform grabs the headlines, I hope that we critically evaluate each of the various proposals instead of uncritically accepting only the Clinton proposal. Make no mistake, physicians as well as patients are looking for reforms and our goals should be the same -- resolving problems without destroying the strengths of medical care. Physicians need less paperwork, fewer hours on the phone justifying treatment given to patients, and fewer burdensome regulations that do nothing to improve medical care. Patients need to make sure that reform preserves their choice of physicians and of treatments available to them.

One of the worrisome aspects of the Clinton plan is: If this is such a complete plan, why are Medicare, Medicaid, Veteran's Administration Hospitals, the Indian Health Service, and all of government (including your senators and congressmen who will vote on this plan) exempt from all provisions of this health care reform? If we are really serious about reforming the system, we will give the same choices and options to everyone. Congress should have to comply with every law which it passes for the rest of us. If we allow all these exemptions, we will soon be enmeshed in the same problems as we are now, as each program fights for funding dollars.

The media has repeatedly used a figure of 37 million uninsured (not a very reliable figure, by the way) -- many of these are unemployed, and the Clinton plan has made no provisions for the unemployed.

Maybe we should focus on the fact that at least 227 million Americans are insured and consider ways to make that insurance more affordable, such as community rating and having individuals and families purchase policies directly, like automobile or homeowner's insurance, encouraging price and benefits comparison. The government could make this portion of income deductible and the amount employers now spend on employee insurance as benefits would be given instead to employees as salary. Vouchers would be given to those below the poverty level to buy insurance. Buying policies in this manner ensures portability of insurance. Guaranteed insurability at a community-rated premium would ensure that everyone could purchase health insurance.

As we proceed with the reform debate, we should make sure that our efforts result in meaningful, workable long-term changes for the better with the least disruption to the patient-physician relationship. The bureaucracy should be minimal because the more involvement by the government, the more costs are generated which have nothing to do with actually providing medical care.

I believe the Clinton plan is unnecessarily complex and creates too much expensive government bureaucracy to be acceptable to the majority of Americans. To paraphrase former Health and Human Services Director Louis Sullivan -- a government-run health care system will combine the efficiency of the post office with the compassion of the IRS. We forget that vision at our peril.

Ronald E. Cordell, M.D.
Charleston

WILLIAM C MORGAN, Jr., M.D., F.A.C.S.
Otologist
Diplomate, American Board of Otolaryngology
OTOLOGY: DISEASES & SURGERY OF THE EAR

Sheri L. Jeffries
Audiologist

304-345-7100

Complete Audiological Services • Hearing Aid Dispensing & Service
Assistive Listening Devices • Electronystagmography • ABR

ST. FRANCIS MEDICAL PLAZA • 331 LAIDLEY STREET, SUITE 602 • CHARLESTON, WV 25301

At Mid-Winter

Physician assisted suicide, estrogen replacement therapy subjects for "Controversies in Medicine"

Physician assisted suicide and estrogen replacement therapy will be the two featured topics of discussion for the "Controversies in Medicine Session" on Saturday, January 22 during the WVSMA's 27th Mid-Winter Clinical Conference at Lakeview Resort and Conference Center in Morgantown.

Presenting their views on physician assisted suicide will be **Robert T. Hall, Ph.D.**, a professor of sociology at West Virginia State College, and **J. David Daniels, M.D.**, of the Huntington Internal Medicine Group, Inc. The positive aspects of estrogen replacement therapy will be discussed by **Donald W. Cox, M.D.**, a professor and director of the Residency Training Program in the Department of Obstetrics and Gynecology at the WVU School of Medicine, and "Arguments That Have Been Against Universal Use of Post-Menopausal ERT" will be highlighted by **Elliott W. Chideckel, M.D.**, a professor of medicine in the Section of Endocrinology/ Metabolism at WVU.

Biographical information about these speakers begins below and additional details about this year's Mid-Winter Clinical Conference can be obtained by contacting Nancie Divvens at (304) 925-0342. A preliminary program is printed on page 506 in this issue and a registration form is published on page 507.

Hall

Daniels

Cox

Chideckel

Panelists highlighted

Dr. Hall received a B.A. degree in classics and philosophy from Trinity College in Hartford, Ct., in 1960 and then obtained a M. Div. degree in theology from Episcopal Divinity School in Cambridge, Mass., in 1963. He continued his education at Drew University in Madison, N.J., where he received a doctorate degree in philosophical theology in 1967. Ten years later, Dr. Hall furthered his studies at the University of Pittsburgh, where he received both a master's and a doctoral degree in sociology.

During his career, Dr. Hall has held many academic appointments including serving on the faculty at Shimer College in Illinois from 1966-68, being a professor of philosophy and sociology at the University of Steubenville in Ohio from 1968-85, and teaching at the University of Dayton from 1973-84. In 1985, Dr. Hall became executive director of Common Cause in West Virginia and he held this post until he accepted his present position as professor of sociology at West Virginia State College.

In addition to being a professor at West Virginia State College, Dr. Hall is also a part-time faculty member at the University of Charleston in the Jones-Benedum College of Business, and is an adjunct associate professor of ethics at the WVU College of Graduate Studies. Since 1988, Dr. Hall has also been the director of the West Virginia Business and Professional Ethics Project.

This year, Dr. Hall completed a master's degree in business administration at the University of Charleston. He has written many articles on ethics and sociology and is currently a commentator for *Morning Edition* on West Virginia Public Radio. Very active in educational programs, Dr. Hall coordinates business ethics conferences for the West Virginia Business and Professional Ethics Project and CME conferences for the Medical Ethics Advisory Group at Charleston Area Medical Center.

Dr. Daniels is a native of Huntington who received his B.S. degree from Marshall University in 1962 and his medical degree from the Medical College of Virginia in 1966, where he also completed his internship. From 1967-69, Dr. Daniels did a residency in internal medicine at the Cleveland Clinic, where he also completed a fellowship in hematology and oncology.

A diplomate of the American Board of Internal Medicine and the American Board of Medical Oncology, Dr. Daniels is on the staffs of St. Mary's Hospital and Cabell Huntington Hospital and serves as chairman of the ethics committees at both of these facilities. A former medical director of Hospice of Huntington, Dr. Daniels is a member of the Academy of Hospice Physicians, the AMA, the American Internal Medicine Society, and is a fellow of the American College of Physicians.

Dr. Cox obtained his medical degree from George Washington University in Washington, D.C., in 1957, and then remained at the university to complete his internship. He served in the U.S. Medical Corps from 1956-77 and during this time completed a residency in obstetrics and gynecology at Walter Reed Army Medical Center and a fellowship in reproductive endocrinology at the University of Washington.

After completing a variety of assignments while serving in the military, Dr. Cox retired as a colonel and chief of the Department of Obstetrics and Gynecology at Madigan Army Medical Center in Tacoma, Wash., and relocated to Morgantown in November 1977 to become a

clinical associate professor of obstetrics and gynecology at WVU. In 1980, he was promoted to professor and chairman of the Department of Obstetrics and Gynecology at WVU, and the following year Dr. Cox was named to his present position as professor and director of the Residency Training Program in the department.

An examiner for the American Board of Obstetrics and Gynecology from 1981-90, Dr. Daniels also served on the West Virginia Maternal Health Care Task Force from 1980-91. Certified by the American Board of Obstetrics and Gynecology, Dr. Cox is a fellow of the American College of Obstetricians and Gynecologists and is a member of the American Association for Maternal and Neonatal Health, the American Fertility Society, The Central Association of Obstetricians and Gynecologists, the Association of Professors of Gynecology and Obstetrics and the International Association for Maternal and Neonatal Health.

Dr. Chideckel was born in Baltimore, Md., and received his medical degree from the University of Maryland Medical School in 1969. After interning and completing a residency in medicine at the University of Illinois, Dr. Chideckel furthered his postgraduate studies in medicine at Cook County Hospital and Sepulvida Veterans Administration Hospital. In addition, Dr. Chideckel was a fellow in endocrinology at the University of Washington from 1973-75.

In 1976, Dr. Chideckel became assistant professor of medicine at University Hospital in Boston. He held this post for four years before relocating to Morgantown to accept a position as an associate professor of medicine in the Section of Endocrinology/ Metabolism at WVU. In 1986, Dr. Chideckel was promoted to his present role as a professor of medicine in the section.

During his career at WVU, Dr. Chideckel has served as chairman and as a member of several committees, including the Pharmacy and Therapeutics Committee and the Academic Review Committee of the Department of Psychiatry. In 1985, he was voted Clinician of the Year by the graduating class at the WVU School of Medicine.

A member of the American Diabetes Association and the Endocrine Society, Dr. Chideckel is the author of over 40 articles and abstracts.

Radiology CME series being offered by University of Pittsburgh

The University of Pittsburgh is conducting CME courses entitled "Topics in Radiology" through May. The courses are being presented at the Sheraton Hotel at Station Square in Pittsburgh and CME credits are offered.

The next event is set for February 11-12 and is focused on neuroradiology, head and neck imaging, nuclear medicine and women's imaging. The concluding session will take place on May 13 and 14 and will be devoted interventional radiology, chest imaging, musculoskeletal imaging.

For more details, phone Clarence Mason at (412) 647-8261.

AABB to hold national conference concerning transfusion medicine

The American Association of Blood Banks (AABB) will be holding a conference entitled "Transfusion Medicine: Update 1994" on January 28-29, in Seattle, Washington.

The program will provide an overview of recent developments, current research and practices, controversies, advances and future directions in transfusion medicine. Topics include Hepatitis C Virus, Cytomegalovirus, Hematopoietic Growth Factors, Peripheral Stem Cells, Transfusion Associated Graft vs. Host Disease, Liver Transplantation, HLA Phenotyping, Tissue Banking, Hemolytic Disease of the Newborn, Treatment of Hemophilia, Red Cell Substitutes, and Compatibility and Virology Testing. Discount prices for registrations before December 31 are being offered.

For registration information, contact the AABB Education Department at (301) 215-6482.

AHCPR releases three new technical reports

The Agency for Health Care Policy and Research has recently released three new reviews which are available free of charge.

These technical studies are entitled "Lymphedema Pumps: Pneumatic Compression Devices," "Intradialytic Parenteral Nutrition for Hemodialysis Patients," and "Small Intestine and Combined Liver - Small Intestine Transplantation."

To receive a copy of one or all three of these reviews, phone the AHCPR Publications Clearinghouse at 1-800-358-9295.

Postgraduate course in head and neck anatomy scheduled

A four-day course entitled "The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy" will be conducted at the Medical College of Virginia, Department of Anatomy, February 28 - March 3.

Lectures and demonstrations will augment the laboratory work. MCV/ VCU designates this activity for 44 credit hours in Category 1 of the Physician's Recognition Award of the AMA. This program is also approved by the Academy of General Dentistry.

Further information may be obtained from Dr. Hugo R. Seibel, Department of Anatomy, Box 709, Medical College of Virginia, Richmond, Va. 23298.

Information sought for cancer directory

A new resources directory for cancer patients is being developed by the Cancer Program Patient/Family Education Committee at the Robert C. Byrd Health Sciences Center of West Virginia University.

The committee, which includes representatives from the HSC, plans to publish a comprehensive directory that includes information about resources not only within the HSC, but also in local communities and statewide.

"We urge anyone who works with cancer patients and their families to contact us with information," says Natalie Ames, manager of the Mary Babb Randolph Cancer Center (MBRCC) Cancer Education Project, who chairs the committee. "We want the directory to be as inclusive and useful as possible."

Send written material to Cancer Education and Information, MBRCC, P.O. Box 9350, Morgantown, W.Va. 26506-9350, or phone Ames at 599-1496.

1994 Mid-Winter Clinical Conference

Preliminary Program

Thursday, January 20, 1994

9 - 4:30 p.m.	Conomikes Seminar - **Managed Care: Preparing for the Clinton Health Plan**
5:30 p.m.	WV Chapter, American College of Physicians - Associates Committee/Organizational Meeting
6 p.m.	WV-ACP Registration
6 - 10 p.m.	WVSMA Executive Committee Dinner/Committee Meeting
7 - 9:30 p.m.	WV-ACP Breakout Sessions

Friday, January 21, 1994

7:15 a.m.	WVC-ACP Registration/Continental Breakfast
7:30 a.m.	Breakfast with the Professors, WV-ACP
Noon	WV-ACP Annual Council Luncheon
1 - 4:30 p.m.	Exhibit Visitation/WVSMA Registration

FIRST SCIENTIFIC SESSION

"Moving Points in Medicine" - Jointly Sponsored by the ACP/WVSMA

1:30 p.m.	**"Polymyalgia Rheumatica and Giant Cell Arteritis"** Gene G. Hunder, MD, FACP
2:15 p.m.	**"Management of Complex Cardiac Dysrhythmias"** Ross J. Simpson, MD, FACP
3:30 p.m.	**"GI Potpourri"** Alvin M. Zfass, MD, FACP
4:15 p.m.	**"Health Care Decision Making in West Virginia: Effect of the New Statutes"** Alvin H. Moss, MD, FACP
5:30-7 p.m.	Reception - WVU/MU

PHYSICIAN/PUBLIC SESSION

"Health System Reform: The States' View"

James L. Comerci, MD, WVSMA President, Moderator

7 - 9 p.m.	**"Oregon"** Ralph Crawshaw, MD, University of Oregon Medical School
	"Vermont" Arnold Golodetz, MD, Burlington, VT
	"West Virginia" James L. Comerci, MD, President of the WVSMA

Saturday, January 22, 1994

7 a.m.	WVSMA Medical Education Committee
8:30 - 4:30 p.m.	Exhibit Visitation/WVSMA Registration

SECOND SCIENTIFIC SESSION

"Controversies in Medicine"

9 a.m.	**"Physician Assisted Suicide"** Robert T. Hall, Ph.D. (pro), James D. Daniels, MD (con)
10:30 - noon	**"Estrogen Replacement Therapy"** Donald W. Cox, MD (pro), Elliott W. Chideckel, MD (con)
noon	Noon Luncheon Meetings
	WVSMA Cancer Committee
	Association of Local Health Officers of WV
	WV Psychiatric Association
	WV State Neurosurgery Society
	Young Physician Section
12-1:30 p.m.	**Lunch and Learn**

THIRD SCIENTIFIC SESSION

"Symposium on Environmental Medicine and Patient Communication"

2-5 p.m.	Presented by the National Institute for Chemical Studies
4 p.m.	WVSMA Annual Meeting Program Committee
7 p.m.	CNA/MCIG Reception

Sunday, January 23, 1994

7 a.m.	WVSMA Council Meeting
7:30 a.m.	WVSMA Surgery Section Meeting
8:30 - 11 a.m.	Exhibit Visitation/WVSMA Registration

FOURTH SCIENTIFIC SESSION

"Potpourri of Topics"

9 a.m.	**"The Role of Carotid Endarterectomy"** Howard Kaufmann, MD, WVU, Morgantown
9:30 a.m.	**"Ambulatory HIV"** Maurice A. Mufson, MD, MU, Huntington
10:30 a.m.	**"Norplant"** Robert Nerhood, MD, MU, Huntington
11 a.m.	**"Identifying an Adolescent Alcoholic"** Nicole Cavendish, MD, WVU
1 p.m.	**WVSMA House of Delegates (if requested)**

WVSMA / WV-ACP

1994 Mid-Winter Seminars and Scientific Conferences

January 20-23, 1994

Lakeview Resort and Conference Center

The WVSMA' s Mid-Winter Sessions will be held in conjunction with the Third Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians.

For conference information, contact Nancie G. Divvens of the WVSMA at (304) 925-0342.

Lakeview is offering special room rates for people who are attending the conference. For room reservations, contact Lakeview Resort directly at (800) 624-8300.

For those fitness-minded individuals, remember to pack your swimsuit and workout clothes!

Lakeview offers numerous recreational facilities and activities including:

* Indoor swimming pool * Aerobics classes * Nautilus and free weights * Life cycles
* Indoor tennis, racquetball and wallyball * Whirlpool and saunas

1994 Mid-Winter Clinical Conference

Name _____

Address _____

City _____ State ____ Zip Code _____

Specialty _____

Payment by: ___ Check ___ Visa ___ MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WV-ACP (only)	$50	____
	WV-ACP and WVSMA Conferences		
	member	$125	____
	non-member	$175	____
Additional:			
Thursday, January 20			
Conomikes	members (each)	$195	____
	2 or more	$175	____
	non-members (each)	$225	____
	2 or more	$200	____
Saturday, January 22			
Lunch and Learn			
	member/non-member	$35	____
	spouse/student	$20	____
		TOTAL:	____

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

CAMC/Robert C. Byrd Health Sciences Center of WVU - Charleston

December 2
"Teleconference on Emergency Medicine Update," noon - 1 p.m., HSC and other satellite locations

Marshall University - Huntington

December 4
"Breast Cancer Prevention and Treatment," Karen A. Johnson, M.D., of the National Cancer Institute, 1:30 p.m., MU Student Center

December 6
"Pediatric Transport and Stabilization," Huntington Medical Community Foundation Outreach Conference, 7 p.m., Louisa, Ky.

December 7
"Women and Heart Disease" (jointly sponsored by the MU School of Medicine and Huntington Internal Medicine Group), 1 p.m., HIMG

December 9
"Management of Severe Migraine Pain" (sponsored by the MU Dept. of Family and Community Health), 12:30 p.m., Cabell Huntington Hospital

"Physician to Physician/Peer Review," 7 p.m., South Williamson, Ky.

Raleigh County Medical Society - Beckley

November 30
"Rhinitis and Sinusitis and Treatment," Robert Call, M.D., 6:30 p.m., Black Knight Country Club

December 2
"Acid Related Diseases Update," Colin W. Howden, M.D., 6:30 p.m., Black Knight Country Club

December 13
"Pre-malignant Breast Disease," David Page, M.D., 6:30 p.m., Raleigh General Hospital

December 16
"Update on Asthma," Syed Rehman, M.D., 6:30 p.m., Black Knight Country Club

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Fairmont ★ Fairmont Clinic, Dec. 15, 1 p.m., "Attention Deficit Hyperactivity Disorder," Bharati Desai, M.D.

Gassaway ☐ Braxton County Memorial Hospital, Dec. 8, 7 p.m., "About Pediatric Transport," Pediatric Transport Team

Man ☐ Man Appalachian Regional Hospital, Dec. 15, 7 p.m. TBA*

Montgomery ☐ Montgomery General Hospital, Dec. 1, 12:15 p.m. "General Management of the Overdose Patient," Greg Rosencrance, M.D.

Ripley ☐ Jackson General Hospital, Dec. 10, 12:15 p.m. "T.B. Update," Elizabeth Funk, M.D.

* *To be announced*

STICK WITH CHRISTMAS SEALS.® USE THEM TO FIGHT LUNG DISEASE.

AMERICAN LUNG ASSOCIATION®
1-800-LUNG-USA

Space contributed by the publisher as a public service.

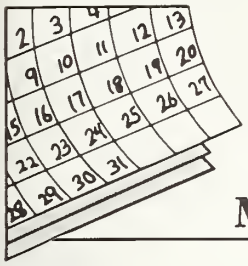
A mammogram is a safe, low-dose X-ray that can detect breast cancer before there's a lump. In other words, it could save your life and your breast.

If you're a woman over 35, be sure to schedule a mammogram. Unless you're still not convinced of its importance.

In which case, you may need more than your breasts examined.

Find the time.
Have a mammogram.

AMERICAN CANCER SOCIETY®



Medical Meetings

December

2–Complications of Diabetes Mellitus (sponsored by PharmaDesign Training), Philadelphia

3-5–American Academy of Psychiatrists in Alcoholism & Addictions, West Palm Beach, Fla.

3-6–Society For Ear, Nose & Throat Advances in Children, Inc., Pittsburgh, Pa.

3-7–American Society of Hematology, St. Louis, Mo.

6-7–An Evidence-Based Health Care System: The Case for Clinical Trials Registries (sponsored by the NIH), Bethesda, Md.

14–Preparing for Electronic Patient Record Systems: A One-Day Seminar (sponsored by the Medical Records Institute), New York, N.Y.

January

2-6–10th Annual Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law (sponsored by the American Society of Law, Medicine & Ethics and the Boston University School of Medicine), Maui, Hawaii

6-9–National Association of EMS Physicians, Naples, Fla.

9-12–American College of Nuclear Physicians, Phoenix, Ariz.

18-22–American Group Practice Association, Palm Desert, Calif.

20-22–28th Annual Meeting of the Neurosurgical Society of the Virginias, White Sulphur Springs, W.Va.

27-29–13th Annual Big Sky Pulmonary Ski Conference (sponsored by American Lung Association of Montana), Helena, Mont.

27-30–20th Annual Postdoctural Education Conference (sponsored by the Society of Teachers and Family Medicine), Tucson, Ariz.

27-Feb.1–American Academy of Otolaryngic Allergy, Tampa, Fla.

28-29–Transfusion Medicine: Update 1994 (sponsored by the American Association of Blood Banks), Seattle, Wash.

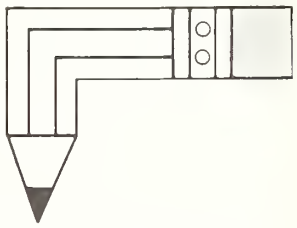
30-Feb. 4–Westwood Winter Skin Seminar, (sponsored by Westwood - Squibb Pharmaceuticals), Vail, Colo.

31-Feb. 2–Cardiovascular Conference at Snowshoe (sponsored by the American College of Cardiology), Snowshoe, W.Va.

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



A Plea to Smokers

At times I cough, I gag, I choke
From pipe, cigar or cigarette smoke.
It's quite all right to smoke, I suppose
So long as your smoke avoids my nose.
Perhaps you don't mind cigarette breath
Emphysema, cancer or even death.
Crush your butts in an ashtray, try to learn
That furniture, drapes and carpets burn.
So smoke all you want, I do not care
Just so long as you do not foul my air.
I should say, though, before this poem ends
That I still count some smokers among my friends.

Harold L. Saferstein, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

" WE REMOVED ALL THE SUGAR, CAFFEINE, FATS AND CARCINOGENS, AND THERE WASN'T ANYTHING LEFT."

Successful Money Management Seminars

FOR WEST VIRGINIA STATE MEDICAL ASSOCIATION MEMBERS AND THEIR SPOUSES

— BY POPULAR DEMAND! —

■ Charleston December 1, 8 and 13
At the WVSMA Office in Kanawha City

Comprehensive Seminar Agenda

SESSION 1

- Your Foundation for Financial Independence
  - Why Everyone Needs Financial Planning
  - Six Main Objectives of Financial Planning
  - Reallocating Your Income
  - The Success Triangle™
  - Six Main Reasons People Fail Financially
  - Take Advantage of Your Lifetime Earning Power
  - Become Financially Independent;
  - The Eighth Wonder of the World—Compound Interest
  - The Effects of Inflation
  - Your Tax Bracket—How it Affects Your Financial Plan
- Putting Your Dollars to Work—Part I
  - Importance of Cash Reserves
  - Types of Cash Reserves
  - Restricted Cash Reserves
  - Tax-Deferred Fixed Annuities
  - Fixed-Income Securities
    - Government Securities
    - Corporate Bonds
    - Municipal Bonds
- Putting Your Dollars to Work—Part II
  - Equity Investments
    - Common Stock
    - Preferred Stock
    - Reading the Stock Tables
    - Risk Factors
    - Managed Accounts
  - Ten Steps to Financial Success
    - Your Personal Financial Plan—The Key to Your Success

SESSION 2

- Putting Your Dollars to Work—Part II
  - Mutual Funds
    - Families of Funds
    - Types of Funds
    - Dollar Cost Averaging
    - Selecting Specific Funds
    - Asset Allocation
  - Guaranteed Versus Equity Investments
  - Limited Partnerships
  - Tangible Assets
  - College Funding
- Retirement Planning
  - Social Security
- 401(k) Plans
- 403(b) Tax-Sheltered Annuities
- Simplified Employee Pensions (SEP-IRA)
- Individual Retirement Accounts (IRA)

SESSION 3

- Retirement Planning (continued)
  - Tax-Deferred Variable Annuities
  - Systematic Withdrawal Programs
  - Risk Management
  - Insuring Your Most Valuable Asset
  - Long-Term Health Care
  - Life Insurance
  - Enhancing Your Pension Benefits with Life Insurance
  - Estate Planning
    - Objectives of Estate Planning
    - Probate-Should it be avoided?
    - Living Revocable Trusts

SESSION 4

Optional

Everyone attending this seminar is entitled to a personal financial planning consultation after the conclusion of Session Three. This is your opportunity to ask specific personal questions regarding your financial future at no additional cost.

ENROLLMENT FORM

(Member's Name) _____ (Spouse's Name) _____

(Mailing Address) _____

(Telephone Number) _____ (Seminar Location I Plan To Attend) _____

Call (304) 925-0342 for more information.

Registration Fee: $250 (member) $125 (spouse)

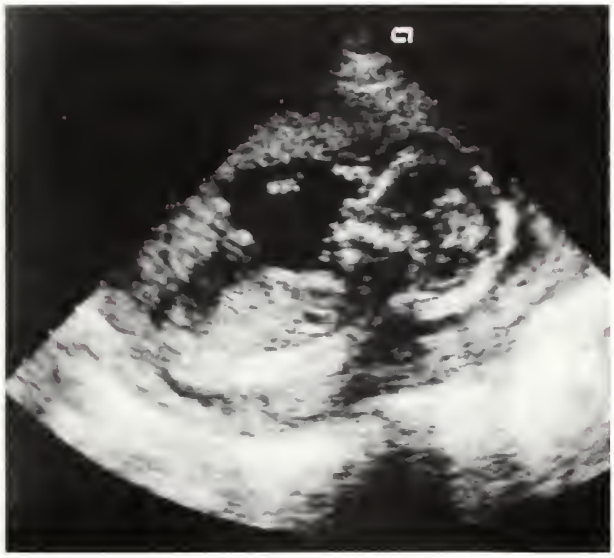
Bonus for early registration: If registration is confirmed 10 days prior to the seminar, the spousal fee will be waived.

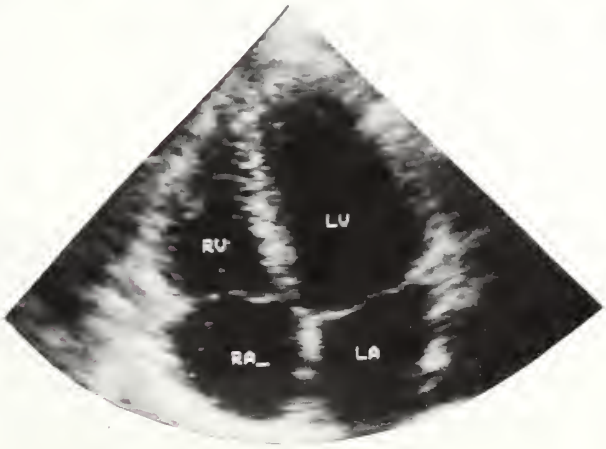
* Make check payable to West Virginia State Medical Association
* Mail enrollment form and fees to: West Virginia State Medical Association
  P. O. Box 4106
  Charleston, WV 25364

Professional Medical Ultra-SONICS, Inc.

Professional Medical Ultrasonics, Inc.
"a full service ultra sound laboratory"
412 Carriage Drive — Beckley, West Virginia 25801
304/252-0609

Doppler
B-Scan
Real Time





Ophthalmology
Breast
Thyroid
Encephalography
Carotid Artery
Peripheral Vascular
Echocardiography
Abdominal
Obstetrical

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

State resident receives national health award

C. E. "Jim" Compton, a coal executive from Bridgeport, has received the national Secretary's Community Leadership Award for his efforts in founding and promoting school health initiatives in West Virginia. He was presented the award by Governor Caperton during a special ceremony at the State Capitol on October 21.

In 1987, Compton provided the leadership and support to establish a pilot public/private health education program in Harrison County schools. The program has received numerous state and national awards, and today benefits over 3,500 children. Due to Compton's support and the innovative suggestions of school staff, students now have daily physical activity programs and more nutritious foods in the cafeteria.

Compton has also funded teachers' efforts to integrate health education with subjects such as reading, math, science and physical education. Children carry valuable messages about nutrition education to their parents, thus improving their health at home as well.

Appointed co-chairman of the Governor's Task Force on School Health in 1990, Compton helped establish the West Virginia Healthy Schools Program, which now includes 10 counties and more than 45,000 students, with more counties being added each year. Last year, West Virginia received a five-year, $6 million grant from the Centers for Disease Control and Prevention to continue work on the Healthy Schools Program and to serve as the site of the National Training Center for Comprehensive School Health Programs.

For more information about the Healthy Schools Program, contact Bob Boggs at (304) 558-0644.

Two state programs win national health promotion awards

The Jackson County Dental Program of the Pilot Club of Jackson County and the West Virginia Wellness Through Education Program of the Monongalia PATCH and the West Virginia University Extension Office have received the U.S. Department of Health and Human Service's Secretary's Outstanding Community Health Promotion Award.

Dentists in the Jackson County Dental Program volunteer time and facilities to provide dental care to students with limited family incomes. Students are recommended to the program by school nurses, and members of the county's Pilot Club review applications, determine eligibility, make the appointments and transport students to the dentists. Club members also teach students the importance of good dental hygiene, cover the cost of outside lab fees and pay dentists $25 for each exam.

In its first year, the program helped 25 students and attracted the services of eight dentists. School personnel also report that students' self esteem, attitudes, attendance and participation in class and extracurricular activities has improved.

West Virginia Wellness Through Extension groups have been established throughout Monongalia County in an effort to eliminate unhealthy sedentary lifestyles among area residents. The program was developed by the Monongalia County Planned Access To Community Health (PATCH) project, in cooperation with WVU's Health Education Program.

Each three-month session includes height, weight and blood pressure assessments; weekly educational and exercise sessions; and, postsession assessments. Since the program began in October 1988, participants have lost a total of more than 3,000 pounds, developed healthier eating habits and lowered their blood pressures.

For more details on community health programs, call Ed Phillips at (304) 558-0644.

Brooke County paramedic wins award

Paul Sicurella, a paramedic and assistant supervisor with the Brooke County Emergency Medical Services has been selected as this year's recipient of the Samuel W. Channell Memorial Award for Excellence in Emergency Medical Services. He was honored during the annual state EMS conference in Canaan Valley.

Sicurella began his career in 1973 as an EMT and is presently one of the state's longest continuous service paramedics. He has been a member of the Brooke County EMS since its inception in 1974 and served as director from 1987 to 1991. With more than 20 years of service, Sicurella is a respected practitioner, as well as an instructor, and serves on numerous state, regional and local committees.

Rural practitioners, programs honored

The first annual Governor's Rural Health Awards were presented during the West Virginia Rural Health Conference in Beckley last month.

Rural Health Practitioner of the Year honors went to Susan A. Schmitt, M.D., medical director of St. George Clinic in Tucker County. Dr. Schmitt has provided community-oriented primary care to area residents for more than 10 years, and was instrumental in obtaining grants which have enabled the clinic to grow from a small trailer setting to a modern, 15-room building.

Robert L. Harman, administrator of Grant Memorial Hospital, was honored for Outstanding Rural Health Achievement. He has served his region for more than 28 years and has established networking among community providers which serve as a state and national model.

The Outstanding Rural Health Program award was presented to Shenandoah Health Center's Maternity Program. This Berkeley County clinic delivers high quality services to more than 900 women a year, utilizing a comprehensive, multidisciplinary approach.

620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5

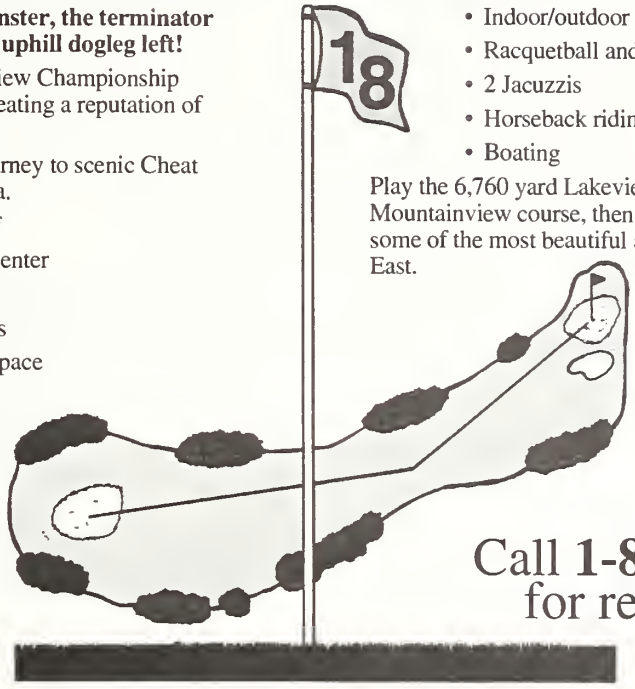
"Nobody Gets Home In Two"

And no wonder . . . this is the monster, the terminator of all holes, at 620 yards with an uphill dogleg left!

The famous hole #18 on the Lakeview Championship Golf Course is a legend in itself, creating a reputation of "Nobody gets home in two".

But that's not the only reason to journey to scenic Cheat Lake in Morgantown,West Virginia.

- 36 holes of Championship Golf
- $2 million Fitness and Sports Center
- 187 guest rooms and suites
- 75 two-bedroom condominiums
- 24,000 square feet of meeting space
- 4 restaurants and lounges
- 3 swimming pools



- Indoor/outdoor tennis courts
- Racquetball and wallyball
- 2 Jacuzzis
- Horseback riding
- Boating

Play the 6,760 yard Lakeview course and the 6,447 yard Mountainview course, then you'll know you've played some of the most beautiful and challenging golf in the East.

LAKEVIEW RESORT & CONFERENCE CENTER

Call **1-800-624-8300** for reservations.

620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5

620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5

620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5 • 620 YARD PAR 5

Highland Hospital

Inpatient Treatment Program for Schizophrenia or Schizoaffective Disorders

A treatment program is available with an investigational medicine for acute exacerbation of Chronic Schizophrenia or Schizoaffective Disorder.

This clinical trial is open to healthy males or healthy sterile females from 18-65 years of age. Patients must be able to give informed consent and agree to a four week hospital stay.

If medication is effective and participants wish to continue out-patient treatment with the medication, it can be provided for a one-year period. There is no charge for the inpatient or out-patient programs.

For more information, call: Charles C. Weise, M.D. at (304) 925-2159.

Highland Hospital is located at 56th Street and Noyes Avenue, S.E., Charleston.

ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

New faculty announced

The WVU School of Medicine has welcomed 75 new faculty members:

MORGANTOWN CAMPUS

Behavioral Medicine & Psychiatry
Lyndra J. Bills, MD
Martin L. Boone, PhD
Virginia L. Goetsch, PhD
Herbert C. Haynes, MD
Joseph Jurand, MD
Alfred Kasprowicz, PhD
Carol Paris, MD
Calvin Sumner, MD
David Withersty, MD

Community Medicine
John M. Cavendish, EdD
Karen K. Douglas, PhD
Vickie Douglas, PhD
Kenard McPherson, EdD
William E. Reger, EdD
Pete Shaffron, EdD

Family Medicine
Glen Aukerman, MD
Vincent W. DeLaGarza, MD
Robert M. Gerbo, MD
Michael C. Maroon, DO
R. Gregory Juckett, MD
C. Daniel Ogle, MD

Medicine
Filitsa H. Bender, MD
Dan Bonner, MS
Randall Bryner, EdD
Jaimela Dulaney, MD
Kevin Gibson, EdD
Mark T. Hoffman, MD
Guy Hornsby, PhD
Paul Marks, MD, MPH
Rebecca J. Schmidt, DO
Linda Stark, MD
Rachel Yeater, PhD

Microbiology/Immunology
William R. McCleary, PhD

Neurology
Laurie Gutmann, MD
Raj Sheth, MD

Obstetrics/Gynecology
Candace Chidester, MD
R. Gerald Pretorius, MD
Tom Turner, MD

Institute for Occupational and Environmental Health
John J. Coumbis, MD, MSPH
Janie R. Vale, MD, MSPH

Ophthalmology
Lionel Chisholm, MD
David Kostick, MD
Jean Vahey, MD

Orthopedics
Thomas A. W. Gruen, MS

Otolaryngology
Michael K. Hurst, DDS, MD

Pathology
Linda L. Cook, MD
Roger S. Riley, MD, PhD

Pediatrics
Arpy A. Balian, MD
Evan A. Jones, MD, PhD
Frank G. Keller, MD
Dianne G. Muchant, MD
Linda S. Nield, MD
Martin E. Weisse, MD

Pharmacology/Toxicology
Stephen G. Graber, PhD

Physiology
David L. Kreulen, PhD

Positron Emission Tomography Cnt.
Naresh C. Gupta, MD

Radiology
Jeffery Hogg, MD
Leroy J. Korb, MD

Division of Physical Therapy
Corrie Mancinelli

CHARLESTON DIVISION

Behavioral Medicine
Vasanta V. Giri, MD
Carol A. Klein, MD
Gail L. Lehman, PhD
Nida-Victoria Nicasio, MD

Family Medicine
C.H. Mitch Jacques, MD, PhD
Sven T. Jonsson, MD

Medicine
Kevin C. Dupke, MD
Molly John, MD
Arvind G. Kamthan, MD

Obstetrics/Gynecology
Fernando O. Recio, MD
Todd C. Resley, MD

Pediatrics
Manual J. Caceres, MD
Felix R. Shardonofsky, MD
Naser Tolaymat, MD
A. Margarita Torres, MD

Surgery
James W. Kessel, MD

Benedum Foundation gives $780,000 to CREM

The Claude Worthington Benedum Foundation has contributed $780,000 to the Center for Rural Emergency Medicine (CREM).

A total of $420,000 was given to provide support for the next three years to the Emergency Medicine Physician Assistants Master's Program, a joint effort by WVU and Alderson Broaddus College to provide advanced training to physician assistants working in emergency departments in the state.

The Benedum Foundation also gave $360,000 to CREM to create the Management Assistance Program for Squads (MAPS), a cooperative project involving CREM and the West Virginia Office of Emergency Medical Services. MAPS will help rural ambulance squads obtain computer equipment, software, and training for administrative tasks, and for computer access to data from CREM and other resources.

Gupta to direct PET center operations

Dr. Naresh C. Gupta has been named to lead the Positron Emission Tomography (PET) unit at the HSC.

Dr. Gupta, currently medical director of the Center for Metabolic Imaging at the Creighton University Medical Center in Omaha, will coordinate patient treatment and research using the new PET unit.

The President Series - Symbolizing Quality and Excellence

Crafted from select walnut veneers and hand-rubbed finishes, The President Series mirrors the excellence of the leaders it serves.

Subtle details make The President Series the reference in traditional design. Burl Walnut or hand-tooled leather-inlay tops, optional leather-wrapped drawer pulls, and hand-applied decorative molding enhance the beauty of the series.

Participating Dealer for
AMERINET, SUNHEALTH
and VHA ACCESS
Leasing Available

Interior Design Service
Space Planning

Custom Office Furniture, Inc.

1260 Greenbrier St., Charleston, WV 25311, Located two miles north of the State Capitol
Phone: 343-0103 or 800-734-2045

THE WHEELING CLINIC

WHEELING, WEST VIRGINIA 26003

Wheeling, 234-2000 • St. Clairsville, (614) 695-2511 • New Martinsville area, 455-2222 • Wellsburg-Steubenville area, 737-3700
Martins Ferry area, (614) 633-4557 • toll-free no. out of state, 1-800-245-8015

INTERNAL MEDICINE
General
P. R. Hedges, M. D.
R. N. Lewis, M. D. (St. Clairsville)

Peripheral Vascular Disease
J. D. Holloway, M. D.

Cardiovascular
A. M. Valentine, M. D.
W. E. Noble, M. D.
Kris Reddy, M. D.

Rheumatology
R. Vawter, M. D.

GENERAL SURGERY
E. C. Voss, M. D.
G. Galvin, M. D.
E. Cohen, M. D.

UROLOGY
D. C. Trapp, M. D.

OPHTHALMOLOGY
R. V. Pangilinan, M. D.
D. Simbra, M. D.
H. F. Leeper, M. D., Ph.D.
Kathryn M. Clark, O. D.

OTOLARYNGOLOGY/ MAXILLO-FACIAL SURGERY
W. A. Tiu, M. D.
A. G. Matadar, M. D.

RADIOLOGY
Valley Radiologists, Inc.

FAMILY PRACTICE
G. L. Cholak, M. D. (St. Clairsville)
E. L. Coffield, M. D. (New Martinsville)
C. P. Entress, M. D.
T. H. Korthals, M. D. (St. Clairsville)
J. H. Mahan, M. D. (St. Clairsville)

PODIATRY
B. Blank, D.P.M. (St. Clairsville)

DERMATOLOGY
G. A. Ganzer, M. D.

NEUROLOGY
H. L. Kettler, M. D.

BEHAVIORAL MEDICINE
S. D. Ward, M. D. (Martins Ferry)

ANCILLARY SERVICES
Optical
Speech Therapy/Audiology
Counseling/Group Therapy
Biofeedback Laboratory
Electrology/Cosmetic Therapy
Electrocardiography
Electroencephalography
Neurological Studies (Non-invasive)
Roentgenology
24° A/EEG Scanning Service
Cardiac Ultrasound
Clinical Laboratory

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Federally funded Rural Health Center, school offices planned in conjunction with new outpatient facility

Space for outpatient care and clinical teaching at the Marshall University School of Medicine would roughly double through a plan by Cabell Huntington Hospital to build the medical center pictured above for the university's physicians and surgeons. The proposed center will be built just south of the hospital and will consolidate services now scattered among seven Huntington sites. Marshall's federally funded Center for Rural Health, which will be the hub of the school's rural medicine programs, will be built between Cabell Huntington and the medical center.

An ambulatory care center being developed by the School of Medicine and Cabell Huntington Hospital has become the nucleus of a three-project cluster that will also include the federally funded Southern West Virginia Center for Rural Health and, ultimately, some of the school's administrative offices.

Cabell Huntington outlined plans for the projects, whose budgets total $27 million, in an application filed with the West Virginia Health Care Cost Review Authority (HCCRA) in October. Since the scope of the development had grown since Cabell Huntington notified HCCRA of its original plans in 1992, HCCRA requested a revised letter of intent for the ambulatory care center project. The hospital anticipates its certificate of need application will be considered during HCCRA's February review cycle.

The additional opportunities stemmed from the help of U.S. Sen. Robert C. Byrd, according to School of Medicine Dean Charles H. McKown Jr.

"Sen. Byrd's energetic and successful advocacy for the Center for Rural Health took our plans to a whole new level," McKown said. "We now have an unprecedented opportunity to create a modern complex for teaching, patient care and rural support services."

The $4.5 million, 32,000-square-foot Center for Rural Health will serve as the hub of the school's activities to provide and support health care in rural areas. It will also house the Marshall Rural Health Research Institute, an auditorium, conference space, and a health sciences learning resource center.

The ambulatory care center will have four stories and 111,000 square feet of space, approximately twice the school's current space for outpatient services.

No state funding will be used for the projects. Costs will be underwritten by the hospital, the federal government and private sources.

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

The Laser Surgery Center

- 35-bed JCAHO Accredited Hospital
- Ambulatory Care/ Same Day Surgery

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH
EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD
Robert E. Pollard, MD

Specializing in
Head and Neck Cancer Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)
FAX (304) 353-0215

American Medical Association
Physicians dedicated to the health of America

For Your Benefit

AMA brings physicians' system reform concerns to Washington

The AMA continues to work with the Clinton administration and Congress to be sure health system reform preserves the physician-patient relationship. Since introducing the Health Access America proposal in 1990, the AMA has been at the forefront of the health system reform debate.

Many basic principles of Health Access America are mirrored in Clinton's proposal: universal coverage, a national package of health benefits emphasizing preventive care, an employer mandate and insurance reform.

"Both plans seek to build on what already works in health care, and both would make certain that the health care system works fairly for all Americans," said AMA Executive Vice President James S. Todd, MD, in testimony before the Senate Labor and Human Resources Committee.

Dr. Todd also took the opportunity to express concern that the plan does not include "the necessary level of physician participation on behalf of patients."

In testimony before the House Committee on Energy and Commerce, AMA Chair Lonnie R. Bristow, MD, detailed the AMA's differences with the Clinton proposal.

Complicated levels of government regulations built into Clinton's plan cause concern. Dr. Bristow said such levels will add new layers of bureaucracy through the proposed national health board and state-run health facilities.

The plan does not go far enough to limit medical liability costs through caps on noneconomic damages and meaningful limits on attorney fees, Dr. Bristow said. More antitrust relief also is needed to allow physicians to adequately negotiate with large managed care organizations.

Dr. Bristow rejected the rigid budget caps and targets in Clinton's plan. Instead, he suggested developing prospective growth targets that establish flexible spending goals for the health care sector of the economy. These goals would identify specific cost difficulties and solutions. Targets would also allow for meaningful negotiations between physicians and the government.

Dr. Bristow expressed medicine's concern over Clinton's intent to regulate the percentage of physicians in primary care to 50 percent and to control allocation of residency slots.

The AMA's litmus test for the Clinton reform legislation consists of only two questions: Will patients have the freedom to obtain care from the provider and facility of their choice? And, can physicians provide necessary, effective and efficient care without undue restrictions on their clinical judgment?

Prepared by the AMA Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

THE SIGN of the Times

Because there will be times when *just doing it* will mean just taking care of yourself. It will mean admitting, "I'm hurt and I need help." It will mean just calling

THE SPORTS MEDICINE INSTITUTE.

"Professional, experienced, responsive medical care"

Because there will be *those times*

Morgantown Physical Therapy Associates

MONONGALIA GENERAL HOSPITAL CAMPUS

(304) 599-2515

Morgantown Orthopedic Associates

200 WEDGEWOOD DRIVE

(304) 599-0720

Prasadarao B. Mukkamala, MD

Union Square • 1 Monongalia Street • Charleston, WV 25302

Dr. Mukkamala is a Diplomate of the American Board of Physical Medicine and Rehabilitation and the American Board of Electro-Diagnostic Medicine.

Specialist in Electromyography and Nerve Conduction Studies

For appointment, call: **(304) 344-5153**

HEALTHTALK™

ICN is proud to offer **HEALTHTALK**™ to the medical community of West Virginia. This exclusive program was designed to show our appreciation to the many individuals that have contributed to the health and welfare of the residents of West Virginia. To learn more about the special benefits **HEALTHTALK**™ members enjoy, please call your local ICN office.

INDEPENDENT CELLULAR NETWORK

a Wireless One Network company

CHARLESTON	LOGAN	HUNTINGTON	WHEELING	PARKERSBURG
925-4000	752-5200	525-4101	233-5600	485-5600

Alliance News

Alliance to focus on community health issues

The West Virginia State Medical Alliance's Fall Board Meeting took place at Hawk's Nest State Park on October 19 and 20. The fall colors were at their peak and so was the mood of the WVSMAA.

Since one of my goals this year is to help the county alliances form networks with county health departments, I invited George Shaler from the Beckley-Raleigh County Board of Health to address the members about the APEX/PH Program and how each county can form a tobacco control coalition. There are too many health problems for us to solve on our own and the health departments have always been appreciative when alliance members have contacted them to offer assistance.

For example, in Raleigh County, alliance members have formed a community health committee called the Raleigh County Tobacco Control Coalition, which brings together people from business, education and health care. The coalition's goals are to have smoke-free, clean air in public places and to have the law prohibiting the sale of tobacco to minors enforced. It is shocking to note that one in four West Virginians smoke and die from a cigarette-related disease. West Virginia is ranked number one in the nation in the amount of chewing tobacco consumed, and is rated tenth highest in the amount of smoking tobacco used by residents. It is so unfortunate that even though we are one of the most beautiful states in the country, we have lifestyles that make us one of the most unhealthy states.

My second goal for the year is for alliance members to increase awareness of women's health issues, especially breast cancer and lung cancer. Many counties have conducted informational public and radio programs on these diseases, as well as had physicians write articles about them for their local newspapers. I want to continue encouraging the alliance members to join in the battle to help conquer these life-threatening diseases.

Also, at this year's Fall Board Meeting, we discussed my proposal to shorten our annual meeting at The Greenbrier from two days to four days. Sue Bryant offered several different plans and the Executive Board and the entire board decided on the following format:

Friday, August 19

10 a.m. - noon	**Pre-Convention Board Meeting**
12:30 p.m. - 1:30 p.m.	**President's Luncheon**
2 p.m. - 4:30 p.m.	**House of Delegates**
9 p.m.	**Entertainment**

Saturday, August 20

8 a.m. - 9 a.m.	**Past President's Breakfast**
9:30 a.m. - noon	**House of Delegates**
12:30 p.m. - 2 p.m.	**Post Convention Buffet Lunch**
2:30 p.m.	**Recreation (Tennis or Golf)**

The Spring Board Meeting is set for Wednesday, April 20 from 10 a.m. - 4:30 p.m. at the Days Inn in Flatwoods. Please be there!

Carole Scaring
WVSMAA President

Obituary

Clarence H. Boso, M.D.

Dr. Clarence H. Boso, 78, of Huntington, died October 12 at St. Mary's Hospital in Huntington.

A native of Washington, W.Va., Dr. Boso attended Marshall College and then obtained his bachelor of science degree from West Virginia University and his medical degree from the Medical College of South Carolina in 1938. He interned at St. Mary's Hospital in Huntington and opened his practice for obstetrics and gynecology in 1939.

Dr. Boso practiced until 1973 and during his career he was president of the Cabell County Medical Society and president of the West Virginia State OB-GYN Society. A member of the WVSMA since 1939, Dr. Boso was also a member of the AMA, Southern Medical Society, the American Board of OB-GYN and the American College of OB-GYN.

A veteran of WWII, Dr. Boso was a member of the Highlawn Presbyterian Church where he was an elder and a member of the choir for many years.

Dr. Boso is survived by his wife of 56 years, Clara E. Tebay Boso; one daughter, Judy Wagy of Winter Haven, Fla.; two sons, Dr. James Humphrey Boso of San Carlos, Calif., and Dr. John E. Boso of Lexington, Ky.; two brothers, Ray Charles Boso and Jerry Boso, both of Parkersburg; eight grandchildren; and one great grandson.

Memorials may be made to Highlawn Presbyterian Church, 2814 Collis Ave., Huntington, WV 25702.

Precious Life

1-800-877-5833 for information

ST. JUDE CHILDREN'S RESEARCH HOSPITAL
Danny Thomas, Founder

Society News

McDowell

At the society's September meeting, members voted to donate $50 to the McDowell County United Way. They also discussed the importance of expressing their views to the media about President Clinton's health care reform plan.

During their October meeting, members discussed the need to elect new officers in November if the society continues its existence. A decision was made not to appoint a nominating committee, but to nominate candidates for office from the floor and vote by a show of hands or by secret ballot.

Monongalia

The speaker for the October meeting was Robert W. Keefover, M.D., of the Department of Behavioral Medicine at WVU, who explained the diagnosis and management of Alzheimer's Disease.

The following 22 new members were presented via first reading: Drs. Glen Aukerman, Filitsa H. Bender, Candace C. Chidester, Lionel D. John Chisholm, Linda Lou Cook, Jaimela J. Dulaney, Robert Feldman, Laurie Gutmann, Jeffrey P. Hogg, Michael K. Hurst, Evan A. Jones, Frank G. Keller, Leroy J. Korb, David A. Kostick, Michael C. Maroon Jr., Linda S. Nield, Charles D. Ogle, Rebecca Schmidt, Raj Sheth, Linda J. Stark, Tommy Turner and Jean B. Vahey. Dr. Greco's application for retired membership was approved unanimously, as was Dr. Anderson's appointment for medical director of the county Emergency Medical Service.

In other actions, Dr. Sebert conducted a lengthy discussion about donations to local political candidates who are supportive of the society's views, and Dr. Stead delivered a brief report on the WVSMA's Legislative Committee.

AMERICAN MEDICAL ASSOCIATION
YOUR HEALTH
TIPS FROM THE AMERICAN MEDICAL ASSOCIATION

Second-Hand Smoke—The Invisible Killer

By James S. Todd, M.D.
Executive Vice President,
American Medical Association

(NAPS)—Did you know that sitting in the smoking section of your favorite restaurant could jeopardize your health? Or that smoking in your home could cause asthma in your child?

Thousands of innocent people die every year from exposure to "second-hand" or passive smoke. And many more thousands suffer from heart disease because of this invisible killer.

"Passive smoke can cause lung cancer in nonsmoking adults, leading to 3,000 deaths a year."

The Environmental Protection Agency (EPA) recently issued a report identifying the dangers of passive smoke. The report said passive smoke can cause lung cancer in nonsmoking adults, leading to 3,000 deaths a year.

The EPA also said passive smoke increases risk of acute lower-respiratory and middle-ear infections, asthma, and respiratory irritation for children exposed to tobacco smoke in the home.

Smokers claim the right to smoke. But that is not a license to kill others. Non-smokers should guard their health by actively encouraging laws to protect themselves.

And if you do smoke, stop now.

Smoking kills 435,000 Americans a year. That's a tragedy. A worse tragedy, however, is that many innocent children will suffer serious health problems—even die—because of smokers who are thoughtlessly spreading illness and death.

New Members

We would like to welcome the following new members to the WVSMA:

Herman Heck Jr., M.D.
2828 1st Avenue
Suite 510
Huntington, WV 25702

William L. Hirsch Jr., M.D.
1000 Locust Street
Fairmont, WV 26554

Kurt Palazzo, M.D.
Wheeling Hospital
Professional Building 4
Suite 401
Wheeling, WV 26003

Elizabeth Ann Roseberry, M.D.
830 Pennsylvania Avenue
#406
Charleston, WV 25302

PHYSICIAN FOLLOW THROUGH

It's the professional edge in patient satisfaction and medicine compliance.

Prescribing the right medicine isn't enough. It's important to follow through and explain how and when to take it, precautions and side effects.

The National Council on Patient Information and Education (NCPIE) has **free** materials to help you talk about prescriptions.

Write for *free information* on patient medicine counseling.

Or FAX: 202-638-0773

NCPIE
666 Eleventh Street, NW
Suite 810
Washington, DC 20001

WESPAC Members

We would like to thank all the physicians and alliance members who contributed to WESPAC during 1993. The following is a list of contributors since June:

Physicians

Cabell
**Philip R. Stevens

Central
John A. Mathias

Greenbrier
**Stephan R. Thilen
Haven N. Wall Jr.

Harrison
**James E. Bland
**David F. Colvin
**Craig J. Coonley
**Carl R. Fischer III
**Saravut S. Fung
**John P. Galey
**Julian D. Gasataya
*James A. Genin
**David R. Hess
Joseph C. Kassis
**Gerardo M. Lopez
**Amante Lopez
**Shiv U. Navada
**Aristotle A. Rabanal
**Michael Stewart
**David L. Waxman
*Gerald Wedemeyer

Monongalia
*James D. Helsley
Jeffrey Stead

Ohio
Larry A. Dodd

Parkersburg
**John E. Beane
Rutherford C. Sims

Raleigh
**Raleigh County Medical Society
Robert C. Belding
Raquel S. Israel
Richard Richmond
Syed A. Zahir

Tug Valley
*Rao H. Vempaty

Kanawha
*Glenn Crotty Jr.
Douglas Curnutte
Jan Cunningham
Nicholas Cassis Jr.
Lee Neilan

Wetzel
Donald A. Blum

Alliance Members

Cabell
Linda Turner

Central
*Central Medical Auxiliary

Harrison
Sue Bryant

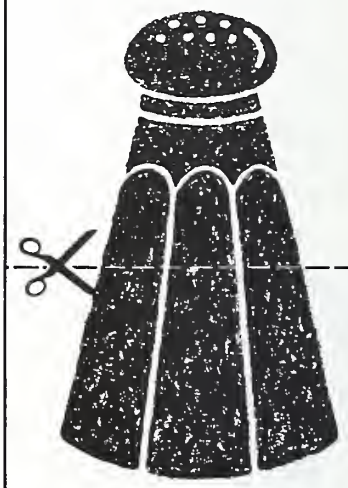
Parkersburg
*Lina Abalos

Raleigh
**Pacita Salon

**Extra-miler member
*Sustainer member

Go against the grain. Cut down on salt.

Adding salt to your food could subtract years from your life. Because in some people salt contributes to high blood pressure, a condition that increases your risk of heart disease.



American Heart Association

EDITOR
Stephen D. Ward, M.D., Wheeling
(Chairman, Publication Committee)

MANAGING EDITOR
Nancy L. Hill, Charleston

EXECUTIVE DIRECTOR
George Rider, Charleston

ASSOCIATE EDITORS
John M. Hartman, M.D., Charleston
Joe N. Jarrett, M.D., Oak Hill
Robert J. Marshall, M.D., Huntington
David Z. Morgan, M.D., Morgantown
Louis C. Palmer, M.D., Clarksburg
Harvey D. Reisenweber, M.D., Martinsburg
Mabel M. Stevenson, M.D., Huntington

RESIDENT EDITOR
Linn M. Mangano, M.D., Morgantown

ADVERTISING DIRECTOR
Michelle Ellison, Charleston

Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the *West Virginia Medical Journal.*

Postmaster send form 3579 to the *West Virginia Medical Journal,* 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

WEST VIRGINIA MEDICAL JOURNAL

(ISSN 0043-3284) is published monthly by the West Virginia State Medical Association, 4307 MacCorkle Avenue, S.E., Charleston, WV 25304.

Subscription Rates: $36 a year in the U.S.; $60 in foreign countries; $3 per single copy. Address all communications to the *West Virginia Medical Journal,* P. O. Box 4106, Charleston, WV 25364.

Due to increasing publication costs, the *West Virginia Medical Journal* will honor no claims for back issues for any reason, unless these claims are received within a 6-month period after issue of publication.

Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, Michigan 48106.

© 1993, West Virginia State Medical Association
1-800-257-4747 or (304) 925-0342

USPS 676 740
ISSN 0043 - 3284

West Virginia Medical
JOURNAL

Contents

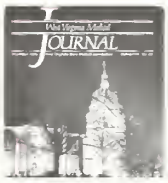
Feature Article
Medical informatics and the rural physician 534

Scientific Newsfront
PH monitoring experience in children with gastroesophageal reflux 538
Manuscript Guidelines 541
Cancer mortality in West Virginia 542
An incidental finding of extreme self-limited thrombocytosis of unknown cause 545

President's Page
Make your opinions heard! 548

Editorial
No, Thank You! 549

Special Departments
General News 550
Managed Care Workshop Registration Form 554
Mid-Winter Clinical Conference Registration Form 555
Continuing Medical Education 556
Medical Meetings/Poetry Corner 557
Bureau of Public Health News 558
Robert C. Byrd Health Sciences Center News 560
Marshall University School of Medicine News 562
Medical Student News 564
1993 Index of Scientific Authors 566
1994 Advertising Rates 568
Classified 569
December Advertisers 570



Front Cover

The brilliant Christmas lights decorating the State Capitol and the Governor's Mansion create a festive holiday scene in Charleston. Photo courtesy of *Robbie Parsons,* South Charleston, W.Va.

Medical informatics and the rural physician

RAYMOND A. SMEGO JR., M.D., M.P.H., F.A.C.P.
JAMES E. BRICK, M.D., F.A.C.P.
Department of Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown, W.Va.

Medical informatics is an emerging discipline of knowledge and techniques concerned with the organization and management of information in support of medical research, education, and patient care (1). Novel or proven approaches to medical information access and delivery include telephone-access medical consultation, interactive computer-to-computer networks, computerized data retrieval and storage systems, visual consulting networks, as well as teleradiology, telepathology, and other developments in telemedicine.

In light of their unique professional stresses and frequent lack of consultative options (2,4), rural clinicians have unique informational needs. When confronted with problems related to patient care, these physicians may lack sufficient time, knowledge of, or accessibility to informational sources. Continuing medical education may take the form of journals, audiocassettes, review courses in larger cities, or perhaps clinical scholar participation at a nearby medical school. However, the lack of a second opinion, often invaluable in day-to-day patient management, can be a critical shortcoming leading to professional isolation and disenchantment in a rural practice setting.

In 1982, the University of Alabama at Birmingham created the Medical Information Service via Telephone (MIST), the first academically-oriented, telephone-accessed, medical consultation program in the United States. The service was university-based and had the participation of all departments within the School of Medicine, as well as several non-medical ancillary health care bodies such as nursing and rehabilitative staff; social services, medical library and multimedia personnel; pharmacy faculty and staff; and hospital administration.

Since this pilot program, about 20 more programs have been developed at other university medical centers including the Medical Access and Referral System (MARS) at the Robert C. Byrd Health Sciences Center of West Virginia University (1-800-WVA-MARS) (5). MARS now answers more than 1,500 calls a month, mostly from rural practitioners in West Virginia.

In addition to its immediate access, question-and-answer consultative function, MARS serves as the information exchange link for a number of special services or clinical research programs. These services and programs include referral and transportation of critically ill newborns, the Emergency Department's trauma transfers, the Critical Care Transport Service, the West Virginia Regional Organ Bank, Mountaineer Doctor Television (MDTV), the Drug Information Center, the Burn Center, the breast cancer program, and the State Tumor Registry.

Telephone consultation can be a widely-used, cost-effective, and educational tool for the community physician confronted with an immediate problem (5,6). Additionally, compilations of incoming call data and utilization patterns can show the most common types of problems confronting rural doctors, which are beneficial in structuring CME courses.

In 1985, through a grant from the National Library of Medicine, the Mercer University School of Medicine developed another prototype medical outreach program -- the first computer-to-computer network (Georgia Interactive Network for Medical Information [GaIN]) and clinical medical linking system for use in rural Georgia (7). Using hospital and private office-based microcomputers, practicing physicians can communicate via electronic mail and teleconferencing, receive advice from colleagues listed in a consultants' register, review educational opportunities on a CME electronic bulletin board, or access biomedical literature through an on-line reference catalog and the GaIN MEDLINE.

After two years of operation, this small pilot model had grown to a network membership of 17 institutions and 150 individual sites. The network is now available to over 13,100 Georgia health care professionals, almost half of whom are practicing physicians, and 40% of whom are practicing in rural towns and areas of population under 20,000.

At WVU, the West Virginia CONSULT program is a similar statewide, computer-based information access and delivery network linking rural health care and information providers. Some of CONSULT's network components include:

1) A Library Information Component (consisting of MEDLINE bibliographic database; OPAC, an on-line catalog of the WVU Library System; Loan Line, facilitating interlibrary loan requests; and REFnet, which provides answers to basic reference questions);
2) A Drug Information Component (comprised of the DRUGnet database of frequently asked drug-related questions; and ADRnet, an information line about adverse drug reactions);
3) A Cancer Information Component (including a cancer database of often asked cancer questions; and ALERT, providing newsworthy cancer-related bulletins);
4) A Communications Component (including MAILMAN, a private electronic mail system; and PARTYLINE, providing special interest electronic discussion forums); and
5) A Service Locator Component (including CE Link, a calendar of statewide continuing education opportunities; and Consultant, a directory of consultants by location and specialty).

New computer applications have the potential for integrating evolving advances in the field of medicine, improving the quality of care, and reducing costs as they have in other industries. For example, computer-based decision support can create algorithms for clinical use in particular medical circumstances (8,9) Tertiary medical centers, especially in rural states, must strive to further develop and experiment with computer-linked outreach programs, as well as devise more innovative methods of diagnostic and consultative evaluation and CME. In rural Utah for example, fetal heart rate transmission via fax machines has been very successfully employed (10), and a new EEG monitoring device hooked to a lightweight computer is making it possible to allow home detection of seizure disorders. In addition, academic teaching sites and community hospitals can be linked together by telepathology to support health delivery in rural areas (11).

Teleradiology, videocameras, microcomputers, and telephone lines or satellite communications, are now capable of transmitting digitalized radiographic images from remote sites to centralized reading zones for interpretation, offering exciting new consultative options (12,13). Diagnosis of images, including those requiring high-spatial resolution (nuclear scans, ultrasonograms, and computed tomograms), may have reliability of up to 98% and with tolerable limitations (14). There are numerous suppliers of teleradiology systems and over 500 such systems are currently in use.

Visual consulting and education networks may also play a future role in enhancing patient care. At the Robert C. Byrd Health Sciences Center in Morgantown, an innovative new program called Mountaineer Doctor Television (MDTV) allows doctors to examine and treat patients via television. The Federal Office of Rural Health Policy recently approved $800,000 to expand the current three-site pilot project to three more outreach hospital locations throughout West Virginia and create another hub site in Charleston. Initial start-up costs at each site are expected to run about $80,000 for cameras and equipment to send television pictures over T1 telephone lines (Copper 24 Channel Service, available almost everywhere in the state). Telephone charges would total about $1,000 to $2,000 a month at each site, a cost easily recovered if only a few patient transfers from rural to much more costly referral hospitals are avoided each month.

Future telemedicine developments in home care may concentrate on monitoring vital signs of respirator- and infusion-therapy patients, with transmission of results to care centers over phone lines. Monitoring devices will transmit time-critical information directly to central computers or to outside consultants via cellular telephone linkages. Recent technologic telecommunications and computer advances (particularly compression technology) have led to a proliferation of new products and services (15). Consequently, home care may become a viable alternative for an even larger array of medical problems.

"Tertiary medical centers, especially in rural states, must strive to further develop and experiment with computer-linked outreach programs, as well as devise more innovative methods of diagnostic and consultative evaluation and CME."

Information retrieval skills must continue to be an essential component of effective medical school training and continuing medical education. All physicians must know how to access and collect clinical information. Ongoing improvements in communication links provided by regional academic medical centers will include even more efficient electronic searching of medical literature through more advanced central and personal computerized data retrieval and storage systems (16).

The availability of various commercial versions of MEDLINE and other electronic bibliographic databases (such as GRATEFUL MED® and LONESOME DOC®) can permit any physician, especially those practicing in remote or underserved areas, to obtain pertinent references quickly. Yet, even when such user-friendly retrieval systems are available to practicing clinicians, they may not feel computer-knowledgeable enough to utilize them.

West Virginia University, as part of a joint effort of the Program in International Health, the CONSULT program, and the Health Sciences Center Library, may soon offer a half-day CME seminar for practicing clinicians or their office secretary, clerk, receptionist, etc. entitled "Office Information Retrieval Made Easy." This course will outline and simplify the techniques used for computer-generated, office-based literature searches that can aid in patient care.

The professional pursuit of each practicing clinician should be lifelong learning in medicine. Medical informatics addresses some crucial obstacles to this goal. Recently, the following key recommendations were adopted by the Association of American Medical Colleges (AAMC) for informatics in medical schools in the U.S. (17):

1) Medical informatics should become an integral part of the medical curriculum. In order to "train" and prepare physicians for the new information age, medical education must effectively provide and ensure computer literacy for medical students, faculty members, and practicing clinicians through hands-on training sessions, classroom coursework, and educational seminars in computerization of the medical office.
2) There should be an identifiable locus of medical informatics in academic medical centers to foster research, integrate instruction, and encourage appropriate use in patient care.
3) Training and career development in medical informatics must be fostered by a series of coordinated actions including: major federal funding through the National Library of Medicine; establishment of 10 centers of excellence to provide the manpower needed to implement these programs on a national scale and to conduct research in medical informatics; and, increased support for such training programs.

PH monitoring experience in children with gastroesophageal reflux

CHRISTOPH U. LEHMANN, M.D.
YORAM ELITSUR, M.D.
Division of Pediatric Gastroenterology, Department of Pediatrics, Marshall University School of Medicine, Huntington, W.Va.

Abstract

Gastroesophageal reflux (GER) has been recognized as one of the leading causes for recurrent vomiting in children. Prolonged pH monitoring is considered the "gold standard" method for the diagnosis of GER in infants, children and adults. This study describes our experience in the diagnosis and treatment of 86 pediatric patients who were evaluated between July 1991 and February 1993 in the pediatric GI clinic in Huntington, W.Va.

Introduction

Gastroesophageal reflux (GER) has been recognized as one of the leading causes for recurrent vomiting in children. GER symptoms are considered in the differential diagnosis of other diseases involving the pulmonary system (reactive airway disease and asthma), CNS system (apnea, choking and SIDS), etc. (1-7).

Among developmentally disabled children, a significant number of patients have GER symptoms causing poor feeding and malnutrition which may result in failure to thrive. In addition, specific GER-related complications have been encountered, i.e., esophagitis and esophageal stricture (8). Chronic esophagitis is a well-known risk factor for the development of Barrett's esophagus, a premalignant state for esophageal cancer development (9). Although rare, esophageal cancer in the pediatric population has been reported (10).

Prolonged pH-monitoring is considered to be the "gold standard" method for the diagnosis of GER in infants, children and adults (Figures 1,2) (2,11-13). This procedure is very reliable (specificity and sensitivity > 95%), and may detect abnormal gastric reflux occuring anytime during the patient's activity -- day or night. Prolonged pH-monitoring is also very efficient in the detection of the association between GER disease and related symptoms in the pulmonary, cardiac or central nervous systems.

This study reports our experience in the diagnosis and treatment of 86 pediatric patients who were evaluated between July 1991 and February 1993 in the pediatric GI clinic in Huntington, W. Va.

Figure 1. The pH probe is inserted via the nasal nare to the distal third of the esophagus. Location is verified by X-ray. The probe is taped to the patient chick and is connected to the recorder.

Figure 2. The pH recorder is hung over the shoulder allowing better mobility and activity for the child during the time of the test. Patient tolerates the procedure very well.

Table 1
Demographics

	Group A	Group B	Total
Number of Patients	52	34	86
Male/Female Patients	23/29	18/16	41/45
Male/Female Ratio	0.8	1.1	0.9
Age Range	8-309 days	1-17.1 years	8 days - 17.1 years
Age Mean	3 months	7.6 years	3.2 years

Table 2
Clinical Symptoms

	Group A	Group B
Number of patients	52	34
Vomiting	37 (71%)	19 (56%)
Apnea	18 (35%)	0 (0%)
Irritability	9 (15%)	0 (0%)
Failure to thrive	9 (15%)	6 (18%)
Abdominal pain/colic	7 (13%)	9 (26%)
Respiratory problem	7 (13%)	8 (24%)
Cyanosis	4 (8%)	0 (0%)
Chest pain/heartburn	0 (0%)	14 (41%)
Dysphagia	0 (0%)	9 (26%)

Table 3
Diagnostic Modalities

	pH-Monitoring	Milkscan	Barium
Total number of patients	86	38	21
Patients with GER	60/86 (70%)	18/38 (47%)*	6/21 (29%)*
Group A with GER	34/52 (65%)	13/25 (52%)	2/6 (33%)
Group B with GER	26/34 (76%)	5/13 (38%)	4/15 (27%)

*$p < 0.004$ compared to pH monitoring group

Table 4
Histological Results

	Group A	Group B	Total
GER*	34	26	60
Upper endoscopy	2 (6%)	21 (81%)	23 (38%)
Esophagitis	1 (50%)	17 (81%)	18 (78%)

*GER confirmed by pH monitoring

Material and methods

The charts of 86 pediatric patients who were evaluated for the diagnosis of GER between July 1991 and February 1993 in the pediatric GI clinic in Huntington, W.Va., were retrospectively reviewed. Their demographic, clinical and laboratory data, treatment and follow-up data were collected (Tables 1-4). Patients were further divided into two age groups: younger (Group A) or older (Group B) than 12 months of age.

Milkscan was performed by giving radioactive-labeled Technetium 99 (500 uci/test) in a standard breakfast (formula for infants and solid food for children). GER was detected by scanning the patient (Elscint SP-4) every 10-15 minutes for an hour. Gastric emptying time during gastric scan is calculated 1 hour after ingestion of the radionucleotide (K-gastric program). In this method, the amount of radio-labeled activity left in the stomach is compared with the percentage of activity detected over the small intestine. Gastric emptying is considered abnormal if > 70% of the technetium meal remains in the stomach after one hour (20).

All patients were admitted to Cabell Huntington Hospital and pH monitoring was done over 17-20 hours. A pH probe made by Synectics Medicals was placed in the distal third of the esophagus and location was verified by X-ray examination. Positive GER was defined as pH less than 4.0 for more than 5% of the total pH-monitoring duration.

Statistics

Chi-square test was used to compare the GER results among pH monitoring, milkscan, and barrium swallow groups. Correlation study was done using regression analysis.

Results

A total of 86 pediatric patients were studied. Ages ranged from 8 days to 17.1 years with the mean age of 3.2 years. There was a similar distribution among both sexes (male/female ratio - 0.9:1). There were more patients in Group A as compared to Group B [52 (mean age - 3 months) and 34 (mean age - 7.6 years), respectively] (Table 1). Patients in Group B had a longer period of symptoms before the diagnosis was made. Eleven of 86 (2/52 from Group A and 9/34 from Group B) were diagnosed with some degree of CNS disabilities, i.e. cerebral palsy, post-meningitis syndrome, neonatal asphyxia, hydrocephalus etc.

Clinical symptoms were different between Group A and Group B. Vomiting, apnea and irritability symptoms were more common in the younger group, while dysphagia and chest pain/heartburn were more prevalent in the older group (Table 2).

A pH-study was performed in all patients without complications. The average duration was 17.3 hours per test. Only 38/86 (44%) had gastric scintigraphy (milk scan) and 21/86 (24%) underwent barium swallow. GER was diagnosed by prolonged pH-monitoring in 60/86 (70%) of the patients (Group A - 65 %, Group B - 76%).

Vomiting and apnea were the presenting symptoms mostly associated with GER (71% and 35% respectively) in Group A, while chest pain, vomiting, and dysphagia were the presenting symptoms mostly associated with GER in group B (41%, 56%, 79%, and 26% respectively).

A significantly higher yield was obtained with pH-monitoring ($p < 0.004$) in detecting GER than the other diagnostic modalities [60/86 (70%) - pH-monitoring, 18/38 (47%) - milkscan and 6/21 (29%) - barium swallow, respectively] (Table 3). In addition, 15 of 20 patients with normal milkscans and 11 of 15 patients with normal barium swallows were found to have GER by pH-monitoring. Three of the 18 patients with abnormal milkscan had subsequently normal pH-monitoring results. There were no false positives in the barium swallow group. Sensitivity and specificity of milkscan and barium swallow to detect GER were low (0.5, 0.53 for milkscan and 0.35, 0.48 for barium enema, respectively). In addition, the correlations between pH-monitoring and milkscan ($r = 0.102$) or with barium swallow ($r = 0.307$) were very low.

Upper endoscopy was performed in only 23/60 (38%) patients with GER confirmed by pH-monitoring. Of the patients who underwent upper endoscopy, a half (50%) of those in Group A and 17/21 (81%) in Group B were found to have esophagitis. Overall, 18/23 (78%) of children confirmed with GER were diagnosed endoscopically with esophagitis (Table 4).

Gastric emptying time was calculated in only 24/38 (63%) of patients who underwent gastric scintigraphy. Only 7/24 (29%) had delayed gastric emptying (defined as > 70% activity in the stomach after 1 hour).

Feeding modifications (including formula change, thickening of feeds and decreased volume/meal) were the major treatment initiated in Group A (77%), while H_2-Blockers were mostly prescribed for Group B patients (56%).

Metoclopramide was used in 14/60 (23%) GER patients and Nissen funduplication was performed in two patients from Group B. One of these children was diagnosed with a severe neurological impairment.

Of the 47/60 (78%) children with GER who returned for follow-up visits, only 3 (6%) had no improvement of their symptoms. The remaining 44 (94%) were improved, and none of the children had worsened.

Discussion

GER is well recognized as a common cause for vomiting in infant and children. Chronic GER may lead to failure to thrive and was implicated in SIDS episodes (3,6,14). Early diagnosis of GER may prevent complications and reduce morbidity and mortality.

In the past, the main diagnostic modality for the diagnosis of GER was barium swallow. Due to the unphysiologic nature of this test and the short monitoring time (usually < 5 minutes in order to shorten radiation exposure), barium swallow has a limited value to confirm the diagnosis of GER. Previous reports have estimated that the false positive and false negative rate for GER diagnosed by barium swallow is 14% - 31% (15).

Gastric scintiscan is another method to diagnose GER. In this method, liquid or mixed meal labeled with radionucleotide (Technetium-99m) is used and reflux episodes are scanned and gastric emptying time may be calculated. Nevertheless, its specificity and sensitivity are still unsatisfactory, and are estimated around 30% (16).

Prolonged pH-monitoring is a new diagnostic modality which offers a longer recording time of reflux periods. This method is based on placing a probe in the lower third of the esophagus and continuous monitoring of the pH in order to detect reflux episodes. Arbitrarily, a pH value below 4.0 was considered as gastric reflux (17). Until recently, the major problem with this method was the difficulty in establishing the "normal" range of reflux episodes. It is also arguable whether the reflux episodes are indeed responsible for the clinical symptoms (8).

Currently, the normal range of gastric reflux is considered to be below 4% - 5% of the total pH-monitoring time (17). Vandenplas and colleagues (18) have monitored 24-hour esophageal pH in 509 normal infants between 3 days and 365 days of age and calculated the normal percentiles. In this study, the 5% cut-off point was correlated approximately at the 50th percentile for ages older than 30 days. Using the 5% margin as the upper limit for normal, we found that 70% of our patients had GER.

In accordance with previous data (19), we found that a high percentage of our GER patients who underwent upper endoscopy had reflux esophagitis (78%). The association of chronic esophagitis and the development of Barrett's esophagus, a premalignant condition for esophageal cancer, should prompt physicians to to make an early diagnosis of GER, in order to decrease morbidity and possible mortality in these children.

As previously reported, barium swallow and gastric scintiscan were less sensitive and less specific diagnostic methods. Using both diagnostic methods, false positive and negative were unacceptably high with a low correlation ($r = 0.1 - 0.3$). Concurring with previous studies (20-22), the majority of our patients did not have a delayed gastric emptying time.

The current acceptable treatment for patients with GER include feeding modifications, pro-kinetic drugs (metoclopramide), anti-acid medication (H_2 blockers, antacids), and surgery (Nissen funduplication). Most of our patients, especially those under 1-year-old, responded well to feeding modification only. A few (14/60) needed metoclopramide treatment and only 2/60 needed surgical intervention (Nissen funduplication).

In summary, we found that with proper clinical suspicion and with the new diagnostic modality, a significant number of children will be diagnosed with GER. In addition, esophageal biopsy (via endoscope or blind capsule) (8) will reveal a great number of patients with esophagitis. From our experience, GER is common in West Virginia children. To reduce morbidity, an aggressive approach to reach the diagnosis by prolonged pH-monitoring and possible esophageal biopsy is recommended.

Acknowledgements

We acknowledge Dr. Stuart Thomas from the Department of Psychology at Marshall University for his assistance in the statistical analysis, and Mrs. Jennifer Long for her excellent secretarial assistance.

References

1. Walsh JK, Farrell, MK, Keenan WJ, et al. Gastroesophageal reflux in infants, relation to apnea. J Pediatr 1981;99:197-201.
2. Orenstein SR, Orenstein DM. Gastroesophageal reflux and respiratory disease in children. J Pediatr 1988;112:847-58.
3. Jeffrey HE, Reid I, Rahilly P, et al. Gastroesophageal reflux in 'near-miss' sudden infant death infants in active but not quiet sleep. Sleep 1980;3:393-9.
4. Malfroot A, Vandenplas, Y, Verlinden M, et al. Gastroesophageal reflux and unexplained chronic respiratory disease in infants and children. Pediatr Pulmonol 1987; 3:208-13.
5. Jolley SG, Herbst JJ, Johnson DG, et al. Esophageal pH monitoring during sleep identifies children with respiratory symptoms from gastroesophageal reflux. Gastroenterology 1981;80:1501-6.
6. Herbst JJ, Minton SD, Book LS. Gastroesophageal reflux causing respiratory

distress and apnea in newborn infants. J Pediatr 1979;95:763-8.
7. Sondheimer JM. Gastroesophageal reflux: Update on pathogenesis and diagnosis. Ped Clin North Am 1988;35:103-16.
8. Orenstein SR. Controversies in pediatric gastroesophageal reflux. J Pediatr Gastro Nutr 1992;14:338-48.
9. Dahms BB, Rothstein FC. Barrett's esophagus in children: a consequence of chronic gastroesophageal reflux. Gastroenterology 1984;86:318-23.
10. Hoeffel JC, Nihoul-Fekete C, Schmitt M. Esophageal adenocarcinoma after gastroesophageal reflux in children. J Pediatr Surg 1985;120:515.
11. Boyle JT. Gastro-oesophageal reflux in the pediatric patient. Gastroenterol Clin North Am 1989;18:315-37.
12. Tappin DM, King C, Paton JY. Lower oesophageal pH monitoring - a useful clinical tool. Arch Dis Child 1992;67:146-8.
13. Lehmann CU. Intra-und postoperatives intragastrales pH-monitoring bei Kindern. Publ: Medizinische Fakultaet der Westfaelische Wilhems Universitaet, Muenster.
14. Spitzer AR, Fox WN. Infant apnea: An approach to management. Clin Pediatr 1984; 23:374-80.
15. Meyers WF, Roberts CC, Johnson DG, et al. Value of tests for evaluation of gastroesophageal reflux in children. J Pediatr Surg 1985;120:515-18.
16. Schendlbeck NE, Heinrich C, Konig A, et al. Optimal thresholds, sensitivity and specificity of long term pH-metry for the detection of gastroesophageal reflux disease. Gastroenterology 1987;93:85.
17. Sondheimer JM. Continuous monitoring of distal esophageal pH: A diagnostic test for gastroesophageal reflux in infants. J Pediatr 1980;96:804.
18. Vandenplas Y, Goyvaerts H, Helven R, Sacre L. Gastroesophageal reflux, as measured by 24-hour pH monitoring, in 509 healthy infants screened for the risk of Sudden Infant Death Syndrome. Pediatrics 1991;88:834-40.
19. Black DD, Haggitt RC, Orenstein SR, et al. Esophagitis in infants: morphometric histological diagnosis and correlation with measures of gastroesophageal reflux. Gastroenterology 1990;98:1408-14.
20. Lorenzo CDI, Piepsz A, Ham H, et al. Gastric emptying with gastroesophageal reflux. Arch Dis Child 1987;62:449-53.
21. Tolia V, Calhoun J, Kuhns L et al. Randomized, prospective double-blind trial of metoclopramide and placebo for gastroesophageal reflux in infants. J Pediatr 1989; 115:141-5.
22. Jackson PT, Glasgow JFT, Thomas PS, et al. Children with gastroesophageal reflux with or without partial thoracic stomach (hiatal hernia) have normal gastric emptying. J Pediatr Gastro Nutr 1989;8:37-40.

Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

ASSOCIATES IN OBSTETRICS AND GYNECOLOGY

OFFERING PERSONALIZED CARE 24 HOURS A DAY 7 DAYS A WEEK
FOR OBSTETRICAL & GYNECOLOGICAL EMERGENCIES & FOR INFANT DELIVERY

OUTPATIENT & OFFICE SURGERY

9 MEMBER GROUP OF OB-GYN SPECIALISTS

CHARLES W. MERRITT, M.D. **MICHAEL T. WEBB, M.D.** **NORMAN W. TAYLOR, M.D.**
ROBERT P. PULLIAM, M.D. **ANGEL L. ROSAS, M.D.** **WILLIAM A. SCARING, M.D.**
OWEN C. MEADOWS, M.D. **NANCY R. WEBB, M.D.** **NORMAN L. SIEGEL, M.D.**

- CONTRACEPTIVE COUNSELING
- INFERTILITY EVALUATIONS
- ARTIFICIAL INSEMINATION
- BREAST SCREENING
- UROLOGICAL EVALUATIONS & TREATMENT

255-1541

410 CARRIAGE DR. BECKLEY

Cancer mortality in West Virginia

R. JOHN C. PEARSON, M.B., M.P.H.
Professor and Chairman, Department of Community Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown, W.Va.

Abstract

Cancer rates have risen in West Virginia since 1950, especially in men. In the 1980s, the increase was in older citizens and for most cancers. An analysis conducted by Dr. Jack Riggs stated that this increase is not the result of environmental hazards, but because we all have to die and other causes of death are decreasing. However, we are dying at an older age.

Introduction

Mortality from cancers in West Virginia among white males was low in the 1950s, climbed in the 1960s, and reached the same level as the nation in general in the 1970s (1) (Table 1). The urban counties had statistically significantly high rates, but only Wheeling in Ohio County had these high rates for all three decades. The rural counties had low rates that did not rise, as was the case nationally in rural areas.

For white females, the West Virginia rates did not rise, as was also the case nationally. In general, Wheeling again had high rates and the rural counties had low rates (1) (Table 2).

During the 1980s, the number of cancer deaths increased by about the same amount that the number of deaths from heart disease decreased, and the overall number of deaths from all causes remained stationary (2) (Table 3). However, the age at death increased. This was particularly true for cancer deaths where deaths under the age of 55 decreased and deaths over 55 increased -- especially after age 65 (Table 4).

During the 1980s, the cancers that increased the most in number per 100,000 included: lung (20.6); colon (4.1); non-Hodgkins lymphoma (3.6); breast and multiple myeloma (1.7); prostate (1.4); esophagus (1.1); and pancreas and brain (1.0) (Table 5). In percent change, non-Hodgkins lymphoma was the leader (95 percent), followed by multiple myeloma (59 percent) and lung and esophagus (35 percent).

Serial Gompertzian analysis

Dr. Jack Riggs, a neurologist at West Virginia University, has used serial Gompertzian analysis to look for an explanation for mortality trends in general and cancer mortality in particular. This form of analysis was first done in the 1820s on a single year's mortality experience by Dr. Gompertz, who made the observation that chronic disease mortality increases exponentially within certain age spans (Figure 1). He also noted that when the mortality rates are converted into logarithms, a straight line increase in mortality results (Figure 2).

Dr. Riggs has been the first to record the results of many years of data for the United States utilizing Gompertzian analysis and he has uncovered some astonishing observations (4-13). He found that for many diseases, the straight lines intersect at a single fixed point, which indicates that the mortality rate at that particular age has not changed over a period of 20 or more years. Indeed, for all causes of mortality, it has not changed in more than 80 years (5).

For one group of conditions, heart

TABLE 1

CANCER DEATH RATES IN WEST VIRGINIA PER 100,000 WHITE MALES

	1950-9	1960-9	1970-9
West Virginia	147	180	203
United States	177	190	204
Cabell County	157	188	238*
Hancock County	192	226*	219
Kanawha County	158	202*	226*
Marshall County	174	213*	223
Ohio County	195*	238*	244*
Hardy County	137	159	137
Pendleton County	104	143	136

*Statistically significantly high rate.

TABLE 2

CANCER DEATH RATES IN WEST VIRGINIA PER 100,000 WHITE FEMALES

	1950-9	1960-9	1970-9
West Virginia	133	127	129
United States	142	132	132
Logan County	135	138	149*
Ohio County	146	159*	152*
Mingo County	133	152*	146
Clay County	111	90	91
Roane County	138	113	99
Pocahontas County	139	132	104
Summers County	149	122	107

*Statistically significantly high rate.

FIGURE 1

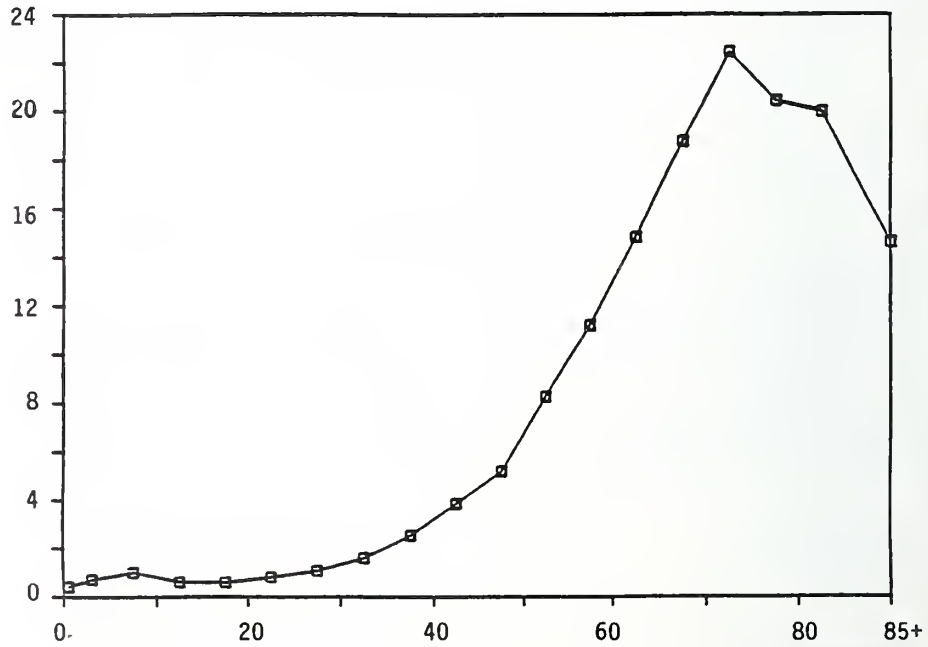


TABLE 3

HEART DISEASE AND CANCER DEATHS IN WEST VIRGINIA 1980-1990

	1980	1990
Heart Disease	7,919	7,036
Cancers	3,673	4,433
Both	11,592	11,469
All Deaths	**19,178**	**19,360**

HEART AND CANCER DEATHS

Time Span	Age < 65	Age > 65	Age > 75
1979-1981 and 1987-1989	1,282 fewer deaths	1,879 more deaths	+1,712

TABLE 4

CANCER DEATH RATES IN WEST VIRGINIA BY AGE GROUPS, PER 100,000

Age Group	1980	1990
15-24	7	3
25-34	14	13
35-44	56	50
45-54	183	167
55-64	443	478
65-74	791	962
75-84	1,067	1,328
85+	1,571	1,631

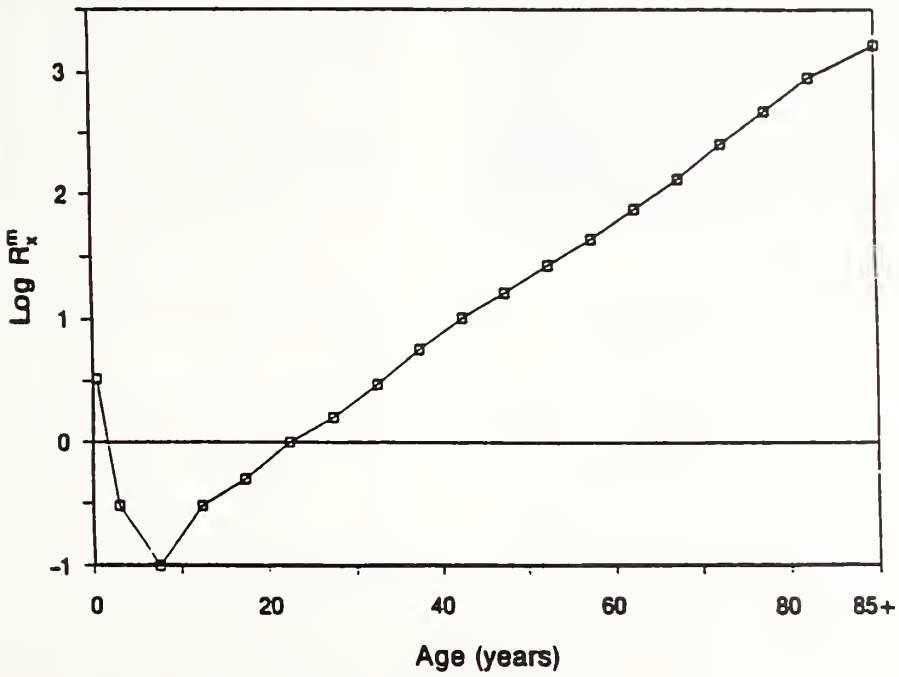
TABLE 5

1980 AND 1990 MORTALITY RATES FOR CANCERS AND PERCENT CHANGE PER 100,000

	1980	1990	Change
Non-Hodgkins Lymphoma	3.8	7.4	+95%
Multiple Myeloma	2.9	4.6	+59%
Lung	59.5	80.1	+35%
Esophagus	3.1	4.2	+35%
Malignant Melanoma	2.4	3.1	+29%
Brain	3.8	4.8	+26%
Liver	3.0	3.7	+23%
Colon	19.2	23.3	+21%
Kidney	4.3	5.2	+21%
Larynx	1.7	2.0	+18%
Prostate	11.9	13.3	+12%
Ovary	5.1	5.7	+12%
Pancreas	9.4	10.4	+11%
Breast	16.5	18.2	+10%
Leukemias	2.8	2.8	—
Bladder	5.2	5.0	- 4%
Gallbladder	2.7	2.5	- 7%
Stomach	6.8	5.8	-15%
Rectum	5.1	3.9	-24%
Cervix	3.5	2.6	-26%
Uterus	4.5	3.0	-33%

* Age standardized to 1990 population.

FIGURE 2



diseases, the intersect point is beyond the normal age span for both men and women with the result that mortality has decreased at all ages consistently over the past 30 years, but more in younger age groups than in older individuals (13) (Figure 3). This pattern is consistent with the improved pattern of mortality observed by McKeown (14) and is ascribed to a general improvement in living conditions, housing, and nutrition.

For most cancers there is an intersect point, but it is found at an earlier age (often in the 50s) with the result that as the straight lines are associated with decreased mortality in younger age groups, there is an inevitable increase in mortality in older age groups as the line passes the intersect point. The greater the decrease in the young, the greater the increase in the older population. Also, the earlier the intersect point, the greater the increase in the older age groups.

The cancers that have increased in older age groups in West Virginia are the same ones that have fixed intersect points at an age within the normal life span (Table 6).

It is also of great interest that there are exceptions among the cancers -- ones that do not conform to this pattern. The exceptions are cancers of the stomach (7), cervix (12), and non-Hodgkins lymphoma (15). The first two of these have had a dramatic decrease in mortality in recent decades and the third has developed an increase. None has this same characteristic intersect point. For the first two, the intersect point has been falling, and for the latter it has been rising.

Dr. Riggs explains this fact by concluding that for most cancers with a fixed intersect point, there is no need to look for environmental factors

FIGURE 3

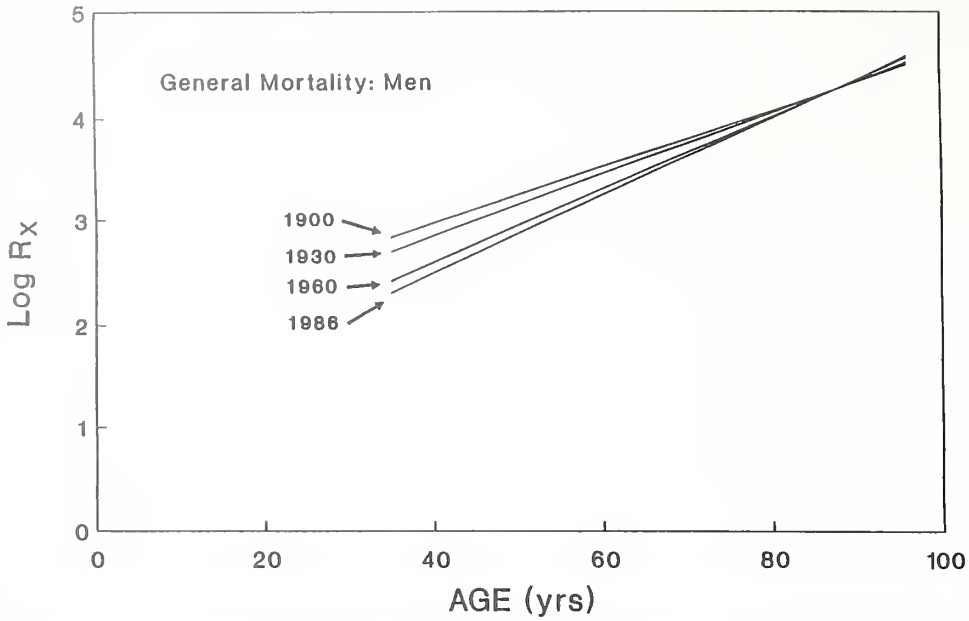


TABLE 6

INTERSECT POINTS FOR SELECTED CANCERS, U.S. DEATHS

	Cross Over Age	Rate At That Age Per 100,000	Years Studied
ALL CANCERS			
Male	54	240	1962-87
Female	56	265	
PROSTATE	62	28	1962-87
BRAIN			
Male	68	27	1962-87
Female	64	12	
PANCREAS			
Male	60	37	1962-87
Female	53	8	
BREAST			
15-40	33	6	1962-87
50-85	60	77	
LUNG			
Male	47	55	1968-86
Female	39	4	
MULTIPLE MYELOMA			
Male	54	3	1968-88
Female	53	2	

to explain the rising mortality in older age groups. It is genetically determined in terms of competitive mortality. As people die less often from other causes, then those with genetic susceptibility will be liable to die from these cancers. However, for cancers of the stomach, cervix, and non-Hodgkins lymphoma, environmental factors are playing a role. It is not known why stomach cancers are decreasing or non-Hodgkins lymphomas are increasing, but we surmise that the use of Pap smears has been playing a role in preventing deaths from cancer of the cervix.

Conclusion

Dr. Riggs' research is of great significance because it is a tool to see if a prevention, a treatment, or a change in the environment is having an impact on patterns of mortality. His research can be used to demonstrate that a new treatment is effective in preventing death, not just delaying it. It also demonstrates that we do not need to pursue exotic environmental factors that might be causing increased cancer deaths in old age if Gompertzian analysis shows the pattern of a fixed intersect point (4).

Not only does Dr. Riggs' research provide a good analysis for the pattern of cancer mortality in West Virginia in the 1980s, but it demonstrates the complete futility of the National Cancer Institute's plans for the year 2000 (15).

References

1. Riggan WB, Van Bruggin J, Aquavella JF, Beaubier J, Mason TJ. U.S. cancer mortality rates and trends 1950-1979. USGPO 1983;1-3, EPA 600/1-83-015a.
2. WV Bureau of Public Health, Office of Epidemiology and Health Promotion. West Virginia vital statistics 1980-1990.
3. Gompertz B. On the nature of the function expressive of the law of human mortality. Phil Trans Roy Soc;1825;115:513-85.
4. Riggs JE. Rising cancer mortality in the United States 1962-1987: evidence against environmental causation. Reg Toxicol & Pharm 1992;16:81-92.
5. Riggs JE. Longitudinal Gompertzian analysis of adult mortality in the U.S. 1900-1986. Mech Age Dev 1990A;54:235-47.
6. Riggs JE. Longitudinal Gompertzian analysis of lung cancer mortality in the U.S. 1968-1987: rising lung cancer mortality is the natural consequence of competitive deterministic mortality dynamics. Mech Age Dev 1991b;59:79-93.
7. Riggs JE. Longitudinal Gompertzian analysis of stomach cancer mortality in the U.S. 1962-1987: a thermodynamic analogy of its declining mortality. Mech Age Dev 1991c ;59:215-28.
8. Riggs JE. Longitudinal Gompertzian analysis of primary malignant brain tumor mortality in the U.S. 1962-1987: demonstration of a disorder displaying complex deterministic mortality dynamics. Mech Age Dev 1991c; 60:123-33.
9. Riggs JE. Longitudinal Gompertzian analysis of primary malignant brain tumor mortality in the U.S. 1962-1987: rising mortality in the elderly is the natural consequence of competitive deterministic dynamics. Mech Age Dev 1991f;60:225-41.
10. Riggs JE. Longitudinal Gompertzian analysis of prostate cancer mortality in the U.S. 1962-1987: a method of demonstrating relative environmental, genetic, and competitive influences upon mortality. Mech Age Dev 1991g;60:243-53.
11. Riggs JE. Longitudinal Gompertzian analysis of pancreatic cancer mortality in the U.S. 1962-1987: distinguishing between competitive and environmental influences upon evolving mortality patterns. Mech Age Dev 1991h;61:113-21.
12. Riggs JE. Longitudinal Gompertzian analysis of cervical mortality in the U.S. 1962-1987: a method of quantitatively demonstrating changing environmental influences upon deterministic mortality dynamics. Mech Age Dev 1992;63:17-129.
13. Riggs JE. Longitudinal Gompertzian analysis of ischemic heart disease mortality in the U.S. 1962-1986: a method of demonstrating the deterministic dynamics describing its decline. Mech Age Dev 1991a;57:1-14.
14. McKeown Thomas. The role of medicine: dream, mirage, or nemesis. Princeton NJ: Princeton University Press 1979.
15. NCI Monographs: cancer control objectives for the nation 1985-2000. USDHHS;NIH;86-2880:Number 2, 1986.

An incidental finding of extreme self-limited thrombocytosis of unknown cause

ALAN W. CASHELL, M.D.
Pathologist, Davis Memorial Hospital, Elkins, W.Va.

DAVID H. BUSS, M.D.
Department of Pathology, The Bowman Gray School of Medicine, Winston-Salem, N.C.

CHRISTINE A. JOHNSON, M.D.
Department of Pediatrics, The Bowman Gray School of Medicine, Winston Salem, N.C.

Abstract

This report describes an 11-year-old male who presented to his pediatrician at the Bowman Gray School of Medicine in Winston-Salem, N.C., because of long standing enuresis. During evaluation and the following two-week period, this patient was found to have extreme thrombocytosis ranging from 2,175 x 10⁹/L to 3,700 x 10⁹/L. In the absence of any apparent reactive cause, a presumptive diagnosis of essential thrombocythemia was made. Although chemotherapy was considered, the patient was temporarily lost to follow-up before there was a final decision about therapy. One year later, this patient's platelet count had spontaneously decreased to normal (273 x 10⁹/L), and has remained normal during a follow-up period of seven years, although only sporadic platelet counts have been obtained. His most recent physical examination revealed no abnormalities. The case is presented as further evidence that extremely high platelet counts are not necessarily dangerous and do not all require therapy.

Introduction

Thrombocytosis is known to be due to clonal (1) and reactive (2) causes. The potential of a very high platelet count to cause thrombotic or hemorrhagic events is controversial and may depend to a certain extent on its cause (3,4) and the age of the patient (5).

This case describes an 11-year-old boy who was discovered incidentally to have a platelet count that was twice well over 3,000 x 10^9/L and several times over 2,000 x 10^9/L. No known cause either reactive or malignant was ever found. The elevated platelet count resolved spontaneously with no apparent sequelae.

Case report

An 11-year-old white male was seen by a pediatrician at the Bowman Gray School of Medicine because of long standing enuresis. Two years earlier, this patient sat on a needle and evaluation showed that it was still embedded within the soft tissue of his buttocks.

A pre-operative laboratory evaluation revealed a platelet count of 2,200 x 10^9/L, which on repeat was 3,300 x 10^9/L. The total white count was 21 x 10^9/L with 59% neutrophils, 18% lymphocytes, 11% monocytes, and 12% eosinophils. The hemoglobin and hematocrit were 12.8 g/dL and 38% respectively, and the red cell indices were normal. The erythrocyte sedimentation rate (ESR) was 13 mm./hour. A liver-spleen scan showed slight splenic enlargement at 14 cm., but was otherwise normal. In addition, an IVP was normal, and an anti-nuclear antibody was negative for all staining patterns. The needle was removed.

Two weeks later, his CBC showed a white count of 17.3 x 10^9/L with 51% neutrophils, 1% bands, 26% lymphocytes, 3% monocytes, and 19% eosinophils. A platelet count done on a Coulter analyzer after a four-fold dilution was 2,175 x 10^9/L; examination of the corresponding Wright-Giemsa stained blood smear confirmed the presence of extreme thrombocytosis. A simultaneous platelet count done on undiluted blood using phase microscopy was 3,700 x 10^9/L. Platelet adhesion and platelet aggregation to collagen was normal. There was no secondary platelet aggregation demonstrated with high molarity ADP.

The secondary wave to epinephrine was very delayed and failed to reach the expected maximum level. A leukocyte alkaline phosphatase was in the high normal range at 100 (normal 40-100). A cytogenetic analysis done on a bone marrow aspirate was normal. The bone marrow was slightly hypercellular with moderate megakaryocytic hyperplasia.

Laboratory studies done seven years previously included a leukocyte count of 11.2 x 10^9/L with 60% neutrophils, 1% bands, 24% lymphocytes, 7% eosinophils, and 8% monocytes. The technologist commented that there were adequate platelets with rare giant platelets seen. No platelet count was done.

A careful history revealed increased tendencies to bruise and to prolonged bleeding after minor mucosal or cutaneous trauma. There had been no change in activity level, weight, or appetite. He had no allergic tendencies, and no history of parasite infection. There was no evidence of an abscess in association with the foreign body.

A tentative diagnosis of essential thrombocythemia was made and chemotherapy to lower the platelet count was recommended. Prior to any action being taken, however, the patient was lost to follow-up. One year later, he again presented to his primary physician for a checkup. He had experienced no abnormal bleeding, thrombosis or other problems during the previous year. A platelet count at that time was 273 x 10^9/L and no objective findings were made.

Seven years after his initial presentation, this patient again presented for a routine physical examination which was within normal limits. A platelet count at that time was 281 x 10^9/L. A CBC revealed a white count of 8.9 x 10^9/L with 61% neutrophils, 30% lymphocytes, 6% monocytes, and 3% eosinophils. The hemoglobin and hematocrit were 15.4 g/dL and 48%.

Conclusion

This is an unusual case of extreme thrombocytosis in a young boy. Causes of secondary (reactive) thrombocytosis are numerous (2,6,7), and most commonly involve infections and/or inflammatory disorders, or trauma. Almost all cases of reactive thrombocytosis have platelet counts less than 1,000 x 10^9/L.

A study of thrombocytosis in children (8) revealed a high incidence of associated infection, with all 15 patients having platelet counts exceeding 700 x 10^9/L and receiving a presumptive diagnosis of infection.

Various methods have been evaluated to differentiate between the elevated platelet count of reactive thrombocytosis and that of myeloproliferative disorders. Messinezy

and colleagues (9) found that splenomegaly greater than 337 cm^3, as measured by radiographic imaging techniques, strongly correlated with myeloproliferative disease.

Majer and colleagues (10) looked at a number of laboratory determinations and found that plasma fibrinogen was the best test to distinguish between the thrombocytosis of myeloproliferative disease and reactive states. A level of less than 5.0 g/L indicated a myeloproliferative disease. Levels greater than 5.0 g/L indicated reactive thrombocytosis. Although platelet aggregation studies tended to show more defects in the myeloproliferative group, a number of reactive thrombocytosis patients had some evidence of defective platelet aggregation.

A myeloproliferative process is very unusual in young people. Out of a group of 280 patients at our institution with platelet counts in excess of 1,000 x 10^9/L, we had only two, ages 14 and 15, who were diagnosed with essential thrombocythemia. However, in the patient described in this report, the slightly enlarged spleen, the extremely elevated platelet count, abnormal platelet aggregation studies, and the lack of a known underlying condition associated with reactive thrombocytosis all tended to favor a myeloproliferative disorder.

To accept this diagnosis, one would have to speculate that a spontaneous regression of the malignant clone had occurred. The initial leukocytosis and eosinophilia suggested an inflammatory reactive process, although the normal ESR is strong evidence against the presence of inflammation. In view of the spontaneous return of the leukocyte and platelet counts to normal, the evidence in this case favors a reactive condition in spite of the extremely elevated platelet count. We are unaware of any other cases of reactive thrombocytosis in which the platelet count exceeded 3,000 x 10^9/L.

An initially similar case has been reported of an asymptomatic 11-year-old girl with platelet counts as high as 1,890 x 10^9/L (11). She was followed without specific treatment for one year and was then lost to follow-up until 11 years later when findings consistent with idiopathic myelofibrosis were present (12).

The clinical significance of thrombocytosis and the advisability of therapy to lower the platelet count remain topics of controversy. Most studies concern adults because of the rarity of myeloproliferative disorders in children. In their study of 129 patients who had extreme thrombocytosis, Buss and colleagues (3) had only 3 patients (4%) with myeloproliferative disorders, and 3 patients (5%) in the reactive group suffering thrombotic complications when their platelet counts were over one million. Bleeding manifestations were seen in 36% of the patients with myeloproliferative disorders, but in only 4% of those with reactive thrombocytosis.

In another study, none of a series of seven patients who had undergone orthopedic surgery and developed platelet counts in excess of 900 x 10^9/L had severe thrombosis or bleeding (13). In addition, Randi and colleagues (4) concluded from their series of patients with thrombocytosis who were under 40 years of age that, while those with polycythemia vera should probably be treated to lower their platelet counts, other disorders associated with thrombocytosis seemed to require no therapy.

Shafer (14) stated that bleeding and thrombotic complications rarely arise in secondary thrombocytosis and that even in myeloproliferative disorders, the literature fails to demonstrate a clear correlation between the platelet count and the incidence of hemorrhage or thrombosis.

In contrast, Lahuerta-Palacios and colleagues (15) stated that untreated thrombocytosis due to essential thrombocythemia is dangerous and should be treated. Of their 19 patients with essential thrombocythemia, 21% had hemorrhagic problems and 63% had ischemic disorders with a high rate of recurrence. They reported disappearance of these complications after therapeutic lowering of the platelet counts. Grossi et al. (16) studied 89 patients with either myelodysplastic or myeloproliferative disease who had platelet counts greater than 700 x 10^9/L. Thromboembolic or hemorrhagic complications were seen in 67.4% of these patients. These authors recommend therapy to lower high platelet counts in every case.

The significance of the absence of therapy in the patient's case described in this article is not completely certain since he has departed from the vicinity. There was no known challenge to this patient's hemostasis by trauma or other means. However, this case provides additional evidence that extreme elevations in the platelet count, in this instance in excess of 3,000 x 10^9/L, does not necessarily lead to harmful results, and indicates the need for caution prior to making a diagnosis of essential thrombocythemia.

Acknowledgement

We thank Dr. Theodore G. Bernthal of High Point, N.C., for providing clinical history and laboratory data.

References

1. Fialkow PJ, Faguet GB, Jacobson RJ, Vaidya K, Murphy S. Evidence that essential thrombocythemia is a clonal disorder with origin in a multipotent stem cell. Blood 1981;58:916-19.
2. Jandl, JH. Blood; textbook of hematology. Boston: Little, Brown and Company, 1987;709.
3. Buss DH, Stuart JJ, Lipscomb GE. The incidence of thrombotic and hemorrhagic disorders in association with extreme thrombocytosis: an analysis of 129 cases. Am J Hematol 1985;20:365-72.
4. Randi ML, Fabris F, Girolami A. Thrombocytosis in young people: evaluation of 57 cases diagnosed before the age of 40. Blut 1990;60:233-7.
5. Hoagland HC, Silverstein MN. Primary thrombocythemia in the young patient. Mayo Clin Proc 1978;53:578-80.
6. Jandl JH. Case records of the Massachusetts General Hospital, Case 11-1988. N Engl J Med 1988;318:691-8.
7. Santhosh-Kumar CR, Yohannan MD, Higgy KE, Al-Mashhadani SA. Thrombocytosis in adults: analysis of 777 patients. J Intern Med 1991;229:493-5.
8. Heath HW, Pearson HA. Thrombocytosis in pediatric outpatients. J Pediatr 1989;114:805-7.
9. Messinezy M, Chapman R, Dudley JM, Nunan TO, Pearson TC. Use of splenic volume estimation to distinguish primary thrombocythaemia from reactive thrombocytosis. Eur J Haematol 1988;40:339-42.
10. Majer RV, Dawe A, Weir P, Jones-Lecointe A, Green PJ. Which tests are most useful in distinguishing between reactive thrombocytosis and the thrombocytosis of myeloproliferative disease? Clin Lab Haematol 1991;13:9-15.
11. Freedman MH, Olivares RS, McClure PD, Weinstein L. Primary thrombocythemia in a child. J Pediatr 1973;83:163-4.
12. Amato D, Freedman MH. Eleven-year follow-up of "primary thrombocythemia" in a child. J Pediatr 1984;104:639.
13. Bunting RW, Doppelt SH, Lavine LS. Extreme thrombocytosis after orthopaedic surgery. J Bone Joint Surg [Br] 1991;73-B:687-8.
14. Shafer AI. Bleeding and thrombosis in the myeloproliferative disorders. Blood 1984; 64:1-12.
15. Lahuerta-Palacios JJ, Bornstein R, Fernandez-Debora FJ, Gutierrez-Rivas E, Ortiz MC, Larregla S, et al. Controlled and uncontrolled thrombocytosis. Its clinical role in essential thrombocythemia. Cancer 1988;61:1207-12.
16. Grossi A, Rosseti S, Vannucchi AM, Rafanelli D, Ferrini PR. Occurrence of haemorrhagic and thrombotic events in myeloproliferative disorders: a retrospective study of 108 patients. Clin Lab Haematol 1988;10:167-75.

Photo: Marty Umans © 1989

A THOUGHT FOR EVERYONE WHO RESENTS SITTING AT A DESK EIGHT HOURS A DAY.

Neuromuscular disease.

It's a large group of disorders that weaken muscles and nerves — devastating thousands of Americans each year.

When neuromuscular disease strikes, many muscle functions are lost. So writers can't write. Musicians can't play. Teenagers can't dance. Babies can't cry. Many patients lose the ability to walk. And once they're in wheelchairs, they'll never get out.

The Muscular Dystrophy Association is striving to cure 40 neuromuscular disorders, including ALS ("Lou Gehrig's disease") and myasthenia gravis. MDA maintains some 230 clinics around the country to help people with muscle diseases. And MDA provides orthopedic equipment and other aids for daily living, all free of charge to patients and their families.

You can help MDA fight neuromuscular disease by sending a tax-deductible contribution today. The Association receives no government grants or patient fees, so its work is funded entirely by private donations.

Next time you think you've been sitting too long, sit one more minute and write a check. You'll be helping thousands of patients stand up to their disease.

MDA®

Muscular Dystrophy Association, Jerry Lewis, National Chairman

To make a donation or bequest to MDA, or for more information on MDA and ALS, write to: Muscular Dystrophy Association, 810 Seventh Avenue, New York, NY 10019. Or contact your local MDA office.

MDA ® is a registered service mark of Muscular Dystrophy Association, Inc.

HELP *with* CHRONIC Pain PATIENTS

NORTHERN WEST VIRGINIA PAIN MANAGEMENT CENTER IS AVAILABLE TO HELP WITH CHRONIC PAIN PATIENTS. WE SPECIALIZE IN CANCER PAIN, BACK PAIN, SYMPATHETIC DYSTROPHIES, MYOFASCIAL PAIN AND HEADACHES.

WITH TWO CONVENIENT LOCATIONS:

99 J.D. ANDERSON DR.
MORGANTOWN, WV

DOCTORS OFFICE BLDG.
SUITE 205
CLARKSBURG, WV

Richard M. Vaglienti, MD, F.A.C.P.M.
Matthew E. Midcap, MD, F.A.C.P.M.
Stanford J. Huber, MD

Northern West Virginia Pain Management Center

For More Information or Patient Referrals Call

1-800-221-6141

President's Page

Carole M. Scaring

Make your opinions heard!

Editor's Note: *This month, as it is customary every December, the message for the President's Page is presented by the president of the WVSMA Alliance.*

Rhetoric is defined as the art of persuasive use of language to influence the thoughts and actions of the listeners. When I recently attended the AMA's National Political Education Conference in Washington, D.C., I heard seemingly unending rhetoric to discuss President Clinton's health plan.

For two days we listened to Republican and Democratic leaders talk about the pros and the cons of the health plan. These speakers included Newt Gingrich, minority whip in the House; Senator Bob Dole, minority leader in the Senate; Congressman Richard Gephardt, majority leader in the House; Congressman George Mitchell; and Senator Jay Rockefeller.

From all their rhetoric I did learn one important fact -- that the president's plan will in no way be the one health system reform bill on Capitol Hill. There are 13 different health reform proposals in the works and more will probably be created in the coming months.

Senator Bob Dole said in his closing remarks that President Clinton seemed flexible on some points in the plan and that nothing was set in stone. He ended his speech with a profound statement that physicians must adhere to if they want their voices to be heard, and that is the fact that there are a lot of undecided people out there and physicians need to take the time to talk, not only to their representatives, but especially with their patients.

As I travel around the state in my role as president of the WVSMAA, I hope to convey this message to all the physicians and auxilians I meet. When a patient comes in for a visit, physicians must learn to express their opinions about key health care issues so patients can get a better understanding of what is at stake. As the spouses of physicians, many of us work in their offices and can help assist in educating patients and their families about health care reform. In addition, as members of our communities we must be active leaders in preventive health programs and other projects to keep the medical community in a positive light.

So, as we prepare to begin the new year, I hope all physicians and auxilians will make a resolution to become better communicators with those people whose lives they touch everyday.

Happy Holidays!!

Carole Scaring
WVSMAA President

No, Thank You!

The American Hospital Association is back to its old tricks. For many years now, from even a casual reading of AHA literature, it has been quite evident that the ultimate aim of this organization is to have the local hospital administrators sign the regular paychecks for every doctor in the community.

Opportunities to promote such ends have come and gone over the years with the coming and going of any serious proposal for changes in health care organization. It really should be no surprise that Hillary's plan once again presents such an opportunity, and that the AHA will once again seize the opportunity to realize its long-held dreams.

The AHA's main problem all along has been how they might organize physicians into manageable (and seizable) groups. Hillary's health care alliances and provider networks present a ready-made solution to this problem. The AHA now talks of "partnerships" and "community care networks." The makeup of these components is not spelled out, but you can bet your 401K that hospital administrators will be playing the tune and doctors will be doing the dancing.

Anyone following national literature, editorials and political commentaries knows that criticism of Hillary's plan has increased, so its chances of passage through the United States Congress are very slim and will continue to diminish. It's a great idea, a lot like being against sin or for mortality, the flag or home cooking. How are you going to argue against good health and free medical care? How are you going to stamp out sin and assure morality? But sin is fun, saints are few and people die inevitably.

The West Virginia Legislature has nothing like the balance of interests that are inherent in Congress. Our good old boys in the Legislature have been doing what they have been told to do by their Democratic leaders for decades. With little doubt they will continue to do this, and there is every likelihood that without extraordinary opposition from the West Virginia Hospital Association and the West Virginia State Medical Association, they will pass health care legislation being tailored by our governor and junior senator to be a dwarf version of Hillary's own giant version of health care.

The West Virginia Hospital Association seems to have hopes that it can vector these plans and shape them to the extent their own hopes, plans and dreams will be fulfilled. And they want us, the doctors, to help our executioners tie the noose!!!

They have announced and are promoting in a variety of ways what they term The West Virginia Hospital Association Principles of Health Care Reform. In explanation, there follows a blizzard of health-related terms some familiar, some unfamiliar, some nominally attractive and some unattractive with little to guide one as to which the WVHA is for and which it is against. Capitation is prominently mentioned several times and the fee-for-service option gets scant and reluctant notice. Stock medical planner euphemisms predominate.

Our reply to this invitation to support their efforts must be a firm "No, thank you!" Such a refusal does not preclude other cooperative efforts with the WVHA elsewhere in the realm of health care. There are many common items of interest between the West Virginia Hospital Association and West Virginia doctors. These items need to be agreed upon through our own organization, the West Virginia State Medical Association. We must start, however, by reassessing a joint position on the upcoming West Virginia Health Care Proposal to be introduced early in the upcoming legislative session. A total and firm resistance to this is a must.

Rockefeller and Caperton fancy themselves becoming Democratic heroes as point men for the Clinton administration, which is obviously having great difficulty selling its health care plan everywhere else. To allow such a plan to be enacted would be a particular disaster for West Virginia, likely to drain it of every self-respecting and competent medical care practitioner within its borders.

We cannot sacrifice West Virginia health care and the good health of West Virginians for the glory of these two political social climbers.

– SDW

At Mid-Winter

Carotid endarterectomy, ambulatory HIV, Norplant, adolescent alcoholism topics for Fourth Session

The Fourth Scientific Session at this year's WVSMA\WV-ACP 1994 Mid-Winter Seminars and Scientific Conferences is entitled "Potpourri of Topics," and will feature professors from West Virginia University and Marshall University providing updates on carotid endarterectomy, ambulatory HIV, Norplant and adolescent alcoholism.

Set for Sunday morning, January 23 at Lakeview Resort and Conference Center in Morgantown, this Fourth Scientific Session will begin with a lecture on "The Role of Carotid Endarterectomy" by Howard H. Kaufman, M.D., professor and chairman of the Department of Neurosurgery at West Virginia University. Immediately following, Maurice A. Mufson, M.D., professor and chairman of the Department of Medicine at Marshall University, will speak on the subject of "Ambulatory HIV." The third presentation, "Norplant," will be given by Robert C. Nerhood, M.D., chairman of the Department of Obstetrics and Gynecology at MU. The concluding lecture for this session is entitled "Identifying the Adolescent Alcoholic," and it will be presented by Nicolene L. Cavendish, director of the Student Assistance Program at WVU.

Brief biographical sketches of these four speakers begin below and additional details about the meeting can be obtained by contacting Nancie Divvens at (304) 925-0342. A registration form for the conference is published on page 555.

Kaufman

Mufson

Nerhood

Cavendish

Lecturers highlighted

Dr. Kaufman received his medical degree from the Columbia University College of Physicians and Surgeons in New York City in 1966. After completing a surgical internship at the University of Minnesota Hospital in Minneapolis, Dr. Kaufman was a fellow at the National Hospital for Nervous Diseases in London from 1967-68.

Following his fellowship, Dr. Kaufman returned to the United States to accept a military assignment as a clinical associate in surgical neurology at the National Institute of Neurological Disease and Stroke at the NIH in Bethesda, Md. He held this post for two years and then continued his postgraduate studies at the Neurological Institute of New York at Columbia Presbyterian Medical Center in New York City, where he completed a four-year residency in neurological surgery.

In 1974, Dr. Kaufman accepted a position as an assistant professor of neurosurgery at the University of Arizona at Tucson. He relocated the next year to Houston to become an assistant professor of neurosurgery at the University of Texas Medical School. Promoted to associate professor status in 1979, Dr. Kaufman also assumed additional teaching responsibilities as a clinical assistant professor in the Division of Neurosurgery at the Galveston branch of UT.

Four years later, Dr. Kaufman moved to West Virginia to become a professor and associate chairman of the Department of Neurosurgery at the WVU School of Medicine. In 1986, he was elevated to his current role as professor and chairman of the department.

During his career, Dr. Kaufman has been a visiting professor at 15 colleges, universities and medical facilities. Very active in many international, national and state organizations, Dr. Kaufman was president of the American Association of Neurological Surgeons in 1992 and currently serves on two committees for this group. In addition, Dr. Kaufman is presently secretary for the American Society for Testing and Materials, is a consultant to the administrative law judges for the Department of Health and Human Services, and is a member of the Health Care Advisory Panel for the Workers' Compensation Division of the West Virginia Bureau of Employment Programs.

An accomplished author, Dr. Kaufman has written three books and has published nearly 150 abstracts, articles and book chapters.

Dr. Mufson is a native of New York City who graduated from Bucknell University in Lewisburg, Pa., and then received his medical degree from the New York University School of Medicine in New York City in 1957. He served as an intern and resident physician at Bellevue Hospital in New York City, and as chief resident physician for the University of Illinois College of Medicine Service at the Cook County Hospital in Chicago.

From 1959-61, Dr. Mufson served with the U.S. Navy Medical Corps. He became a Public Health Service Postdoctoral Fellow in Infectious Diseases at the National Institutes of Health in Bethesda, Md., in 1961, and later joined the U.S. Public Health Service as a commissioned officer. In

1965, Dr. Mufson was appointed to the faculty of the University of Illinois College of Medicine and during the ensuing 11 years he attained the rank of professor of medicine.

In 1976, Dr. Mufson was named the first professor and chairman of the Department of Medicine at the Marshall University School of Medicine. Since he joined the faculty, Dr. Mufson has received Marshall's Meet-the-Scholar Award in fall 1986, been named an Outstanding Researcher by the Marshall University Club of Sigma XI in 1989, and was selected as an Outstanding Clinical Instructor by the Class of 1992.

A fellow of the American College of Physicians and of the Infectious Diseases Society of America, Dr. Mufson is a member of many national medical societies, including Alpha Omega Alpha, the medical academic honor society. A noted author, he has published more than 150 original articles. Dr. Mufson's research interests include studies on viruses causing respiratory tract diseases; bacteria that cause pneumonia and bacteria vaccines; HIV and AIDS; and antibiotics.

Dr. Nerhood was born in Altoona, Pa., and received his undergraduate and medical degrees from WVU. He interned from 1969-70 at Harrisburg Polyclinic Hospital in Harrisburg, Pa., and then returned to WVU for a three-year residency.

In 1973, Dr. Nerhood began practicing at Keesler Air Force Medical Center in Biloxi, Miss., where he was stationed as a major in the U.S. Air Force Medical Corps. After completing his military assignment, Dr. Nerhood practiced in Huntington from 1975-87 at Ob-Gyn Associates, Inc. He relocated to Pittsburgh in 1987 to work in the Department of Obstetrics and Gynecology at Allegheny General Hospital, but two years later he resigned to accept a post at the Department of Obstetrics and Gynecology at Berkshire Medical Center in Pittsburgh.

Last year, Dr. Nerhood moved back to Huntington to become chairman of the Department of Obstetrics and Gynecology at Marshall University. He is currently affiliated with St. Mary's Hospital and Cabell Huntington Hospital, where he was formerly director of both the Maternal Transport System and the Perinatal Outreach Program from 1982-87.

A former president of the medical staff at Cabell Huntington Hospital and of the Cabell County Medical Society, Dr. Nerhood is a member of many national and state organizations including the American College of Obstetrics and Gynecology, the Central Association of Obstetrics and Gynecology, and the American Urogynecologic Society.

Ms. Cavendish received a B.S. degree in social work from WVU in Morgantown in 1972 and then accepted a position for two years with In Touch and Concerned, a social service for the elderly in Morgantown. Two years later, Ms. Cavendish began working in Client Services for the Human Resources Development Foundation, which is also located in Morgantown, and then in 1979 she became a home life specialist at Valley Community Mental Health Center.

In January 1980, Ms. Cavendish joined the faculty of WVU as a field instructor in social work for the Family Education Center. She held this position for 10 years and then continued her education at WVU, where she obtained a master's degree in social work in 1981.

Following her doctoral practicum and internship at WVU, Ms. Cavendish worked as a graduate research assistant in the Department of Behavioral Medicine and Psychiatry at WVU for a year and a half. From October 1983 to June 1985, she was a contract consultant for the Robert F. Kennedy Youth and Adult Correctional Center in Morgantown, and during this time she also provided therapy services for Dr. Paul Frye's private medical practice in Fairmont.

After resigning from her post at the center, Ms. Cavendish continued to provide therapy services at Dr. Frye's practice and also began working as a therapist at the Behavioral Medicine Unit in Fairmont and the Institute for Behavioral Studies in Morgantown. In September 1987, Ms. Cavendish assumed her current role as director of the Student Assistance Program at WVU, where she is also an assistant professor in the Department of Behavioral Medicine and Psychiatry.

A licensed social worker and a certified addiction counselor for the state of West Virginia, Ms. Cavendish recently continued her postgraduate studies and obtained her Ed.D. degree in counseling from WVU. A member of many professional organizations including the National Association of Alcohol and Drug Abuse Counselors and the Western Pennsylvania Society for Clinical Hypnosis, she is currently serving on the West Virginia State Task Force Advisory Committee for Institutions of Higher Education.

Special Workshop

WVSMA President Dr. James Comerci discusses membership issues with participants during the WVSMA Training Workshop which was conducted in Charleston on October 27 for WVSMA officers, counselors, delegates and executive secretaries.

ASAM certification, recertification exams set for Atlanta, L.A.

The American Society of Addiction Medicine (ASAM) will give its 1994 Certification Examination and 1994 Recertification Examination for physicians in addiction medicine on Saturday, December 3, 1994 in Atlanta and Los Angeles. Applications must be postmarked by January 10.

To receive an application, write to ASAM, Certification Department, 5225 Wisconsin Avenue, N.W., Suite 409, Washington, D.C. 20015 or phone (202) 244-8948.

WV-ACP to again co-sponsor First Scientific Session at Mid-Winter

This year's First Scientific Session at the WVSMA's Mid-Winter Clinical Conference is again co-sponsored by the West Virginia Chapter of the American College of Physicians and is entitled "Moving Points in Medicine." Set for Friday, January 21 at 1:30 p.m. at Lakeview Resort and Conference Center, the site for all the 1994 Mid-Winter seminars and scientific conferences, this session will feature four speakers and be moderated by Robert J. Marshall, M.D., F.A.C.P., governor of the WV-ACP.

Gene Hunder, M.D., F.A.C.P., of the Mayo Clinic and Mayo Medical School will begin this program with a discussion of "Polymyalgia Rheumatica and Giant Cell Arteritis." Next, Ross J. Simpson, M.D., F.A.C.P., of the University of North Carolina, will analyze "Management of Complex Cardiac Dysrhythmias." After a break and the presentation of the Laureate Award of the American College of Physicians, Alvin M. Zfass, M.D., F.A.C.P., of the Medical College of Virginia, will present "GI Potpourri," which will also include his views on the semantics of what has long been called "peptic" ulcer disease. The concluding lecture will be delivered by Alvin H. Moss, M.D., F.A.C.P., of West Virginia University, who will provide an overview of "Health Care Decision Making in West Virginia: Effect of the New Statutes."

Information about these four panelists begins below. In addition, details about any of the Mid-Winter sessions or the Scientific Meeting of the WV-ACP, which is being held in conjunction with the WVSMA's Mid-Winter Clinical Conference, can be obtained by calling Nancie Divvens at 925-0342.

Panelists highlighted

Dr. Hunder received his medical degree from the University of Minnesota in 1958. After an internship and early residency training at Strong Memorial Hospital in Rochester, N.Y., he took additional residency training in internal medicine and rheumatology at the Mayo Clinic.

Since 1966, Dr. Hunder has been on the faculty at Mayo as well as served as a consultant in internal medicine and rheumatology. Currently a professor of medicine and head of Mayo's Section of Rheumatology,

Hunder

Moss

Dr. Hunder previously served as chairman of the Clinician Investigator Training Program at the clinic.

During his career, Dr. Hunder has been on the editorial boards of a number of national and international journals pertaining to medicine and rheumatology. He has published extensively about his research interests which include clinical complement abnormalities, giant cell arteritis and polymyalgia rheumatica, and the transient osteoporosis syndrome.

Dr. Simpson received his medical degree from Georgetown University in 1973. His internship, residency in internal medicine, and fellowship in cardiology were served at the University of Illinois in Chicago from 1973-77.

Following his postgraduate studies, Dr. Simpson joined the Division of Cardiology at the University of North Carolina in Chapel Hill, N.C. He currently is a professor of medicine and director of both the Cardiology Inpatient Service and the Cardiac Care Unit at North Carolina Memorial Hospital.

Dr. Simpson also completed the requirements for a master of public health (epidemiology) degree at the University of North Carolina. He has obtained a number of major grants to support his research in epidemiology, clinical cardiology and in electrophysiology; and he has published extensively concerning the genesis of atrial and ventricular dysrhythmias and the use of new agents in the treatment of these disorders.

Dr. Moss received his medical degree from the University of Pennsylvania in 1975, where he was president of the senior class. His residency in medicine was completed at North Carolina Memorial Hospital in Chapel Hill from 1975-78, and his renal fellowship was completed at the University of Colorado from 1978-80.

After his fellowship, Dr. Moss spent three years at Moses H. Cone Memorial Hospital in Greensboro, N.C., and was concurrently an assistant clinical professor of medicine at North Carolina University. In 1983, Dr. Moss joined the faculty at WVU in the Department of Medicine (Section of Nephrology), where he has now attained the status of associate professor of medicine.

Dr. Moss developed a special interest in bioethics, and studied at the Kennedy Institute of Ethics at Georgetown University. He spent the year from 1989-90 as a visiting scholar at the University of Chicago Center for Clinical Medical Ethics. Now, in addition to his clinical responsibilities at WVU, Dr. Moss directs the Center for Health Ethics and Law at the Robert C. Byrd Health Sciences Center of WVU in Morgantown.

Active in teaching and research in the fields of renal physiology and nephrology, Dr. Moss has lectured and published extensively in the fields of bioethics, with a particular emphasis on clinical decisions relating to patients with terminal diseases.

Dr. Zfass graduated from the Medical College of Virginia in 1957. His internship and residency training were completed in New York City at Bellevue Hospital (Cornell Division), New York Veterans Hospital and Memorial Sloan-Kettering Hospital. Dr. Zfass completed subsequent fellowship training in gastroenterology at New York Veterans Hospital.

Later in his career, Dr. Zfass had special training in laser therapy at Tulane University and in endoscopy at Middlesex Hospital in London with Dr. Peter Cotton, who was a speaker at last year's "Moving Points" session. Dr. Zfass is now a professor of medicine at the Medical College of Virginia, where is also director of endoscopy and chief of the Section of Pancreatico-Biliary Diseases.

The recipient of many Teacher of the Year awards at MCV, Dr. Zfass is active on many regional and national committees pertaining to his field. He serves as governor for the Virginia Chapter of the American College of Gastroenterology and has published nearly 50 papers and book chapters.

Graeber to speak at Surgery Section breakfast meeting

Graeber

Geoffrey Graeber, M.D., professor of surgery in the Section of Cardiovascular and Thoracic Surgery at West Virginia University, is the featured speaker for this year's WVSMA Surgery Section breakfast meeting at 8 a.m. on Sunday, January 23, during the WVSMA's Mid-Winter Clinical Conference at Lakeview Resort and Conference Center in Morgantown.

Dr. Thomas Chang, chairman of the WVSMA Surgery Section, is encouraging all interested physicians and other health care professionals to attend Dr. Graeber's lecture on "Thoracoscopy: State of the Art."

Dr. Graeber received his medical degree from the State University of New York in 1971. He completed a surgical internship and a residency in surgery at Johns Hopkins Hospital in Baltimore. Dr. Graeber furthered his postgraduate studies at Upstate Medical Center in Syracuse, N.Y., from 1973-78 with residencies in general and thoracic surgery.

Following his residencies, Dr. Graeber served with the U.S. Army at the Walter Reed Army Medical Center in Washington, D.C., from 1978-1989, obtaining the rank of colonel. In addition, during most of this time, Dr. Graeber was also on the faculty of The Uniformed Services University of the Health Sciences in Bethesda, M.D.

In 1989, Dr. Graeber relocated to Morgantown to become a professor of surgery and director of surgical research at WVU. In addition to his academic responsibilities, Dr. Graeber is a staff cardiothoracic surgeon at both Ruby Memorial Hospital and Monongalia General Hospital in Morgantown, and serves as a consulting surgeon at Washington Veterans Administration Medical Center in Washington, D.C., and the National Cancer Institute in Bethesda, Md. He is a fellow of the American College of Chest Physicians and the American College of Surgeons.

To make reservations to attend this breakfast meeting, please contact Nancie Divvens at 925-0342.

Urological Society's annual meeting set for March 24-25

The West Virginia Urological Society's Annual Spring Meeting will be conducted in Morgantown from March 24-25, and is entitled "Lower Urinary Tract Dysfunction."

For details, contact Douglas E. McKinney, M.D., 11 Chenoweth Drive, Bridgeport, WV 26330, (304) 842-3446.

Touma receives national award

Touma

Joseph B. Touma, M.D., of Huntington, was among 37 otolaryngologist-head and neck surgeons nationwide to receive the American Academy of Otolaryngology-Head and Neck Surgery's prestigious Honor Award at the academy's recent annual meeting in Minneapolis.

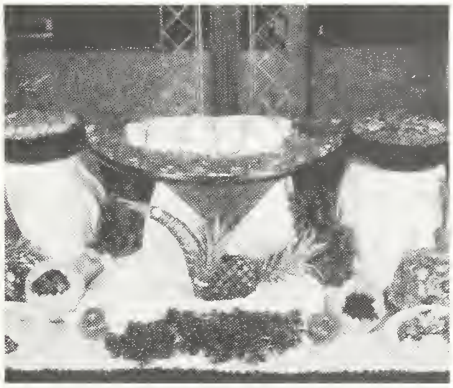
Bestowed since 1934, the award recognizes those who have contributed service to the Academy without renumeration, such as the presentation of an instruction course or paper, or participation on a continuing education committee or faculty. A point system is the basis for granting the award. No more than two points can be earned per year, and a total of 10 points is required. With the inclusion of the 1993 recipients, over 100 Academy members have received the Honor Award.

AABB announces teleconference series

The American Association of Blood Banks (AABB) is holding a series of teleconferences through September.

For details, phone the AABB at (301) 215-6482.

Radisson's Renaissance



CHARMING – COMFORTABLE – CASUAL

The restaurant of choice for all dining occasions or no occasion at all – just for the food! Have a simple breakfast, lunch or dinner anytime. For those days when you're really hungry or want to impress yourself or someone else try –

- **Spectacular Sunday Brunch**
- **Fabulous Friday Night Seafood Buffet**
- **Wednesday Night Unlimited Prime Rib Buffet**
- **Smokehouse Saturday Night**

Radisson Hotel Huntington
1001 Third Ave., Huntington, WV • 304-525-1001

The West Virginia State Medical Association & Conomikes Associates, Inc.

Present

Jan Woerth Ph.D.

MANAGED CARE

Preparing for the Clinton Health Plan

January 20, 1994

Lakeview Resort and Conference Center
Ballrooms 1+2, and lunch 3+4
Morgantown, West Virginia
9 a.m. to 4 p.m. (Lunch provided)

Workshop Outline

1. **Who are the payers**
   - Fee-for-service variations
   - Regional cooperatives and alliances
   - Large companies/self-insured
   - Medicare/Medicaid
   - HMOs, PPOs, other managed care
2. **How will you be paid**
   - Standard benefit packages
   - Co-payment increase
   - Capitation
   - Fees for global services
3. **Collection issues will differ**
   - Co-payments at time of service
   - Withhold and risk pools
   - Out-of-contract services
4. **How certification works**
   - Gatekeeper function
   - Treatment authorizations
   - Hospital authorizations
   - Referral authorizations
   - Denied authorizations
5. **How physicians may reorganize their work**
   - Money issues
   - Income distribution problems
   - Group formations
   - Scheduling issues
   - Staffing for efficiency
6. **How to look at contracts**
   - Key points to include
   - What to watch for
   - Payment issues
   - Termination clauses
   - "Hold harmless" provisions
7. **How to track your results**
   - Determining which plans are favorable and unfavorable
   - Keeping track of your plans
   - Tracking withholds and risk pool utilization

For a FREE Brochure on this seminar or to register, contact Becky Campbell at the West Virginia State Medical Association at (304) 925-0342.

Three FREE Bonuses

• Conomikes Workshop Workbook • 3-month Subscription to Conomikes Medicare Hotline • 3-Month Subscription to Conomikes Reports

WVSMA / WV-ACP

1994 Mid-Winter Seminars and Scientific Conferences

January 20-23, 1994

Lakeview Resort and Conference Center

The WVSMA' s Mid-Winter Sessions will be held in conjunction with the Third Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians.

For conference information, contact Nancie G. Divvens of the WVSMA at (304) 925-0342.

Lakeview is offering special room rates for people who are attending the conference. For room reservations, contact Lakeview Resort directly at (800) 624-8300.

For those fitness-minded individuals, remember to pack your swimsuit and workout clothes!

Lakeview offers numerous recreational facilities and activities including:

* Indoor swimming pool * Aerobics classes * Nautilus and free weights * Life cycles
* Indoor tennis, racquetball and wallyball * Whirlpool and saunas

1994 Mid-Winter Clinical Conference

Name _____

Address _____

City _____ State ____ Zip Code _____

Specialty _____

Payment by: ___ Check ___ Visa ___ MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WV-ACP (only)	$50	____
	WV-ACP and WVSMA Conferences		
	member	$125	____
	non-member	$175	____
Additional:			
Thursday, January 20			
Conomikes	members (each)	$195	____
	2 or more	$175	____
	non-members (each)	$225	____
	2 or more	$200	____
Saturday, January 22			
Lunch and Learn			
	member/non-member	$35	____
	spouse/student	$20	____
		TOTAL:	____

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Robert C. Byrd Health Sciences Center of WVU - Charleston

January 12-13
"A Laparoscopic Approach to Urinary Stress Incontinence"

January 20
"Teleconference on Breast Cancer 1994," Daniel Foster, M.D., Dept. of Surgery, CAMC

January 31-February 2
"Cardiovascular Conference at Snowshoe" (co-sponsored by the American College of Cardiology), Snowshoe, W.Va.

February 3
"Ovarian Cancer Screening: When Is It Helpful?" Fernando Recio, M.D., Dept. of Obstetrics and Gynecology, HSC

Raleigh County Medical Society - Beckley

January 11
"Pediatric Sinusitis," Robert E. Pollard, M.D., 6:30 p.m., Black Knight Country Club

Robert C. Byrd Health Sciences Center of WVU - Morgantown

February 18-20
"Primary Care Perspectives on Women's Health" (sponsored by the WVU Dept. of Family Medicine), Snowshoe Resort, Snowshoe, W.Va.

West Virginia State Medical Association - Charleston

January 20-23
WVSMA/WV-ACP 1994 Mid-Winter Seminars and Scientific Conferences, Lakeview Resort and Conference Center, Morgantown

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Gassaway ☐ Braxton County Hospital, Jan. 25, 6:30 p.m., "Medical Evaluation of Sexually Abused Children," Kathleen Previll, M.D.

Logan ☐ Logan General Hospital, Jan. 21, 11:45 a.m., "Skin Cancer," Brad Cohen, M.D.

Man ☐ Man Appalachian Regional Hospital, Jan. 19, 6:30 p.m., "Preventative Screening in Oncology," Arvind Kamthan, M.D.

Montgomery ☐ Montgomery General Hospital, Jan. 5, 12:30 p.m., "Rheumatoid Arthritis," Michael Istfan, M.D.

Oak Hill ☐ Plateau Medical Center, Jan. 25, 6:30 p.m., "Blood Transfusion," Mary Taylor, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Jan. 12, 7 a.m., "Accidental Hypothermia?"

★ Camden-Clark Memorial Hospital, Jan. 26, 7 a.m., "Is There a Right to Health Care?"

★ Camden-Clark Memorial Hospital, Feb. 9, 7 a.m., "Acute Respiratory Failure"

★ Camden-Clark Memorial Hospital, Feb. 16, 7 a.m., "What's New in the Treatment of Childhood Cancer?"

★ Camden-Clark Memorial Hospital, Feb. 23, 7 a.m., "Return to Work for the Injured Worker: Principles and Caveats"

Philippi ★ Broaddus Hospital, Jan. 6, 7 p.m., "Alzheimer's Disease"

★ Broaddus Hospital, Feb. 3, 7 p.m., "Scoliosis/Spinal Deformity" (Pediatrics)

Point Pleasant ☐ Pleasant Valley Hospital, Jan. 27, noon, TBA, Constantino Y. Amores, M.D.

Ripley ☐ Jackson General Hospital, Jan. 14, 12:15 p.m., "Sinus Diseases and Surgery," R. Austin Wallace, M.D.

Spencer ☐ Roane General Hospital, Jan. 18, 12:15 p.m., "Plastic Surgery for the Primary Care Physician," Alfonso Amores, M.D.

Williamson ☐ Williamson Appalachian Regional Hospital, Jan. 27, 6:30 p.m., "Abdominal Trauma," Bruce Hoak, M.D.

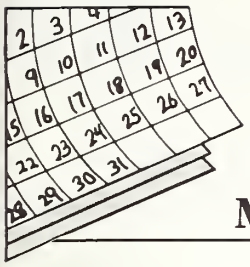
Give your heart an extra helping.

Say no to high-fat foods.

American Heart Association

ALL OF US HAVE THE ABILITY TO MAKE A DIFFERENCE.

Easter Seals®



Medical Meetings

January

2-6–10th Annual Obstetrics, Gynecology, Perinatal Medicine, Neonatology, and the Law (sponsored by the American Society of Law, Medicine & Ethics and the Boston University School of Medicine), Maui, Hawaii

6-9–National Association of EMS Physicians, Naples, Fla.

9-12–American College of Nuclear Physicians, Phoenix, Ariz.

18-22–American Group Practice Association, Palm Desert, Calif.

20-22–28th Annual Meeting of the Neurosurgical Society of the Virginias, White Sulphur Springs, W.Va.

27-29–13th Annual Big Sky Pulmonary Ski Conference (sponsored by American Lung Association of Montana), Helena, Mont.

27-30–20th Annual Postdoctural Education Conference (sponsored by the Society of Teachers and Family Medicine), Tucson, Ariz.

27-Feb.1–American Academy of Otolaryngic Allergy, Tampa, Fla.

28-29–Transfusion Medicine: Update 1994 (sponsored by the American Association of Blood Banks), Seattle, Wash.

30-Feb. 4–Westwood Winter Skin Seminar, (sponsored by Westwood - Squibb Pharmaceuticals), Vail, Colo.

31-Feb. 2–Cardiovascular Conference at Snowshoe (sponsored by the American College of Cardiology), Snowshoe, W.Va.

February

1-5–19th Annual Meeting of the Alliance for CME (sponsored by the George Washington University Medical Center), San Diego, Calif.

11-12–Topics in Radiology (sponsored by the University of Pittsburgh Medical Center), Pittsburgh, Pa.

12–Infectious Diseases (sponsored by Ohio State University), Columbus

18-20–1994 Annual Refresher Course and Conference of the American Academy of Pain Medicine, Orlando, Fla.

20-23–First International Symposium on the Role of Soy in Preventing and Treating Chronic Disease, Mesa, Ariz.

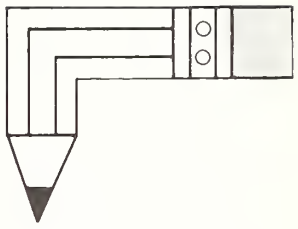
24-Mar. 1–American Academy of Orthopaedic Surgeons, New Orleans, La.

26–Mar. 5–Topics in Gastroenterology and Internal Medicine (sponsored by the George Washington University Medical Center), Marriott's Sam Lord's Castle, Barbados

28-Mar. 3–The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy, Medical College of Virginia, Virginia Commonwealth University, Richmond, Va.

For More Information . . .

Contact the Journal at (304) 925-0342.



Poetry Corner

To the Family of My Dying Patient

You told me you didn't know what to do; here are my suggestions:

Realize that our loved one is dying.

Realize their dying is a graduation to something better -- it's the only way to get better -- remember, spring follows winter.

Be with them -- it's lonely to die. Sit with them, touch them, cry with them.

Love them, make them realize they are special -- review past events, reminisce.

Let them be in charge -- follow their choices, ask about all the things you're afraid to say.

Deal with the fear of death with the faith that all will be alright.

Deal with the fear of the situation with knowledge -- the truth.

Realize that what you don't do now, you can't do later, and with courage you can do it.

Bruce A. Foster, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

"I CAN'T UNDERSTAND A WORD YOU'RE SAYING... STOP TALKING WITH YOUR MOUTH FULL!"

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Community coalitions created to help reduce tobacco use in state

Sixteen community coalitions have been organized to initiate activities to reduce tobacco use in West Virginia. These new groups were funded by the West Virginia Tobacco Control Coalition, through the American Stop Smoking Intervention Study for Cancer Prevention or ASSIST, which is a joint effort of the National Cancer Institute, the West Virginia Bureau of Public Health and the American Cancer Society, West Virginia Division, Inc.

The coalitions are: Smoking Control in Cabell County, Raleigh County Tobacco Control Coalition, Mercer County RETURN, McDowell County Coalition for Tobacco Control, Mingo County ASSIST Project, A Tobacco-Free Boone County, Clay Organized for Wellness' ASSIST Program, Monroe County Tobacco-Free Partnership, Grant County Tobacco Control Coalition, Randolph County Tobacco Education Committee, ASSIST of Marshall County, Monongalia County PATCH Against Tobacco, Mid-Ohio Valley Tobacco Control Coalition, Mineral County School Children Against Tobacco, Ritchie County Tobacco Control Coalition Initiative and Brooke Environment Tobacco-Free.

Coalitions will initiate projects to meet specific community needs. Some planned activities include adding tobacco control to existing DARE programs, assisting worksites in passing tobacco-free policies, creating youth councils to reduce tobacco use among young people, and uniting health and business professionals into community tobacco prevention teams.

For more information on tobacco use prevention, contact Joyce Edwards at (304) 558-0644

Health departments recognized for efforts to improve services

Ten county health departments, Brooke County, Gilmer County, Hancock County, Lewis County, McDowell County, Mid-Ohio Valley, Monroe County, Ohio County, Preston County and Taylor County, have been honored for improving their ability to serve the people in their communities.

The agencies were recognized for successfully completing Phase I of the Assessment Protocol for Excellence in Public Health (APEX/PH). This is a nationwide program that encourages internal capacity building to help local health departments expand their ability to serve the public through preventive health services. It has been implemented in West Virginia as a means to mobilize communities to develop programs specific to their county's needs in meeting the state's Healthy People 2000 objectives.

During Phase I of the APEX project, health department staff members conduct an internal assessment of their organization to identify and prioritize their own strengths and weaknesses. They then develop action plans to upgrade and increase their effectiveness.

The ten health departments that have recently completed Phase I now join Marshall County, Mercer County, Monongalia County, Randolph-Elkins and Beckley-Raleigh County, which completed the process last year. All 15 agencies are now working on Phase II of APEX, the community action phase in which residents are recruited to develop a community health plan. These community health committees have already identified some priorities, such as passing clean indoor air policies, establishing programs to combat heart disease, increasing breast cancer awareness and developing other programs to improve public health.

For more details about the APEX/PH project, contact Ed Phillips at (304) 558-0644.

Report examines cardiovascular disease

According to a new report released by the Bureau of Public Health, almost as many West Virginians die each year from cardiovascular disease than from all other diseases combined, and state residents will continue to die from this cause at an alarming rate unless they improve their health behaviors.

The report entitled "Heart Disease & Stroke: Cardiovascular Disease in West Virginia" examines why the state's death rates for heart disease and stroke have been higher than the national average for the past three decades. Some of the primary reasons cited for the high rate of cardiovascular disease among men and women in the state are unhealthy personal behaviors, including cigarette smoking, lack of exercise and poor nutrition.

For a copy of the report, or for more information on cardiovascular disease in West Virginia, call J.T. Morris of the Cardiovascular Disease and Stroke Program at (304) 558-0644.

Health travel data now offered by CDC

The Centers for Disease Control and Prevention is now offering information via fax concerning immunizations needed for travel out of the country, as well as other details about health problems in other nations.

To receive a listing for the CDC's International Travel Directory, call 404-332-4565 from a regular telephone and follow the prompts. After choosing the correct option, you can request the directory be sent to you through your fax machine. When you receive the directory, you can select what topic or region pertains to your travel plans and then request the information you need. Up to five documents can be requested at one time and additional directories on childhood immunizations and other diseases are also availabble.

For more details about the fax service, call (304) 558-2188.

West Virginia Chapter - American College of Surgeons

Annual Spring Meeting

May 5,6, & 7, 1994

The Greenbrier

White Sulphur Springs, West Virginia

Guest Speakers:

Dr. David C. Sabiston, Jr., Professor and Chairman
Department of Surgery - Duke University Medical Center

Dr. Vaughan Starnes, Chairman, Department of Surgery and
Director of Cardiopulmonary Transplantation, University of Southern California

Dr. Leland J. Foshag, Associate Director - John Wayne Cancer Institute

Jane Rothrock, R.N., Ph.D., President - Association of Operating Room Nurses

Speakers from the Southwestern Pennsylvania Chapter, the West Virginia Chapter and residents from WV training programs will complete the program. Golf tournament and reception on Friday. Ten hours CME. For room reservations, call *The Greenbrier* at 800-624-6070. For information, call Sharon Bartholomew at 598-2802.

Our Name Says It All . . .

turn-key *adj* (1927): built, supplied, or installed complete and ready to operate
Webster's Ninth New Collegiate Dictionary

Fast, efficient, effective, complete.

That's Turnkey Business Systems, an award-winning Medical Manager dealer.

We specialize in the medical market, tailoring practice management systems to meet your special needs.

Lee Bldg. Suite 102 • 30 W. Sixth Ave.
Huntington, WV 25701

(800) 242-5901 / (304) 522-4361

ROBERT C. BYRD HEALTH SCIENCES CENTER

OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

School of Medicine reaccredited by LCME

The School of Medicine has been granted a full seven-year accreditation from the Liaison Committee on Medical Education.

The committee, which is a joint body of the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges, is the chief national evaluation authority for medical schools in the United States.

In their report, the LCME survey team cited the school's strengths as the administration, the commitment of the faculty to teaching, the research programs, the facilities of the HSC, and the coordination among the school, Ruby Memorial Hospital, and Charleston Area Medical Center. The team also commented on WVU's commitment to serving primary care needs of West Virginia - - citing as evidence the Kellogg Foundation and Rural Health Initiative projects, the reorientation of educational programs to a primary care emphasis, and the development of Mountaineer Doctor Television.

The next accreditation review is set for the 1999-2000 academic year.

New drug for prostate cancer to be tested at three state sites

The Mary Babb Randolph Cancer Center, the Veterans Affairs Medical Center in Clarksburg, and the HSC's Charleston Division are among the 222 sites involved in the National Cancer Institute's first large-scale test of a drug to prevent prostate cancer.

Eighteen thousand men age 55 and older will participate in the test of the drug finasteride.

NCI is providing $60 million for the seven-year trial.

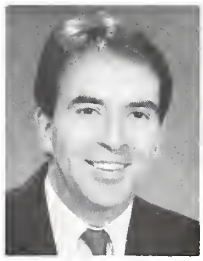
Cancer Center to host regional breast cancer education summit

The Mary Babb Randolph Cancer Center is one of 16 recipients of a grant from the National Cancer Institute and the Susan G. Komen Breast Cancer Foundation to host a regional breast cancer education summit.

Scheduled to be held in Charleston in June, the conference is entitled the North Central Appalachia Leadership Summit, "The Challenge of Breast Cancer," and is designed to provide an overview of educational programs, screening and treatment services, control coalitions in West Virginia and the 29 southeastern counties of Ohio. The summit is geared toward business and community leaders, health care providers and administrators.

The North Central Appalachia Leadership Summit is being held in collaboration with the Charleston Area Medical Center and Riverside Regional Cancer Institute in Columbus, Ohio.

Marrow transplant program achieving high success rates



Lynch

Patients of the new bone marrow transplantation program at WVU's Mary Babb Randolph Cancer Center are doing better than reported national averages, according to Dr. Joseph P. Lynch, director of the adult program and assistant professor of the section of hematology/oncology.

"Of the patients who survived and could be evaluated, the majority (83%) have had complete disappearance of their cancers," says Dr. Lynch. "But it's still too early to determine if this translates into cure."

Of the 45 patients treated in the first 12 months of the program, six died from treatment-related causes, Dr. Lynch said. "That's about half the mortality rate considered standard and acceptable,' at the national level."

Another seven patients survived the transplant, but died later from their cancers. The remaining patients are home, and are currently cancer-free.

Pathology Department names new chair

Mary Ann Sens, M.D., Ph.D., has been named chair of the Department of Pathology and will join the faculty January 1.

Dr. Sens is currently an associate professor in the Department of Pathology and Laboratory Medicine at the Medical University of South Carolina, where she is also director of the Electron Microscopy Laboratory.

A member of numerous professional organizations, Dr. Sens has served as a consultant to many national agencies, including the FBI and the U.S. State Department. She has testified as an expert witness in forensic pathology in more than 300 criminal and civil trials.

New medical director named for Eye Center

Dr. Lionel Chisholm has joined the Department of Ophthalmology as medical director of the University Eye Center and director of the Retina Service.

Dr. Chisholm, one of Canada's foremost retinal surgeons, will serve as professor and vice chair of the Department of Ophthalmology. In addition to caring for patients and teaching at WVU, he is also medical director of the West Virginia Diabetic Eye Care Project, which provides free screenings for diabetic eye disease in rural areas of the state.

Dr. Chisholm previously served on the faculty of the University of Toronto, where he had earlier earned his medical degree and completed ophthalmology training. He was ophthalmologist-in-chief at the Toronto Hospital and vice chair of the Eye Research Institute of Canada.

HealthCare Financial Services

"Your Medical Collection Specialists"

Looking for an edge in healthcare collections?

HFS provides **statewide** service, complete with:

* Automated dialer
* Statewide wats service
* Effective collections on medical accounts
* Trained, experienced staff
* Prompt account acknowledgement

A division of Strategic Health Services, Inc. • Affiliated with Charleston Area Medical Center

1204 Kanawha Boulevard, East • P.O. Box 3882 • Charleston, WV 25338
Phone: (304) 345-4371 • (800) 369-4371 • Fax: (304) 345-4323

Eye & Ear CLINIC OF CHARLESTON, INC.

The Laser Surgery Center

- 35-bed JCAHO Accredited Hospital
- Ambulatory Care/ Same Day Surgery

MEDICAL AND SURGICAL SERVICES PROVIDED THROUGH
EYE EAR NOSE and THROAT PHYSICIANS & SURGEONS OF CHARLESTON, INC.

OPHTHALMOLOGISTS
Robert E. O'Connor, MD
Moseley H. Winkler, MD
Samuel A. Strickland, MD
James W. Caudill, MD
R. David Allara, MD

Specializing in
Cataracts/Lens Implants
Corneal Transplants
Ophthalmic Plastic Surgery
Retinal Surgery
Laser Eye Surgery

OTOLARYNGOLOGISTS
Romeo Y. Lim, MD
R. Austin Wallace, MD
Robert E. Pollard, MD

Specializing in
Head and Neck Cancer Surgery
Ear Surgery
Microsurgery
Endoscopy
Laser Surgery

THE EYE AND EAR CLINIC OF CHARLESTON, INC.
1306 KANAWHA BOULEVARD, EAST
CHARLESTON, WEST VIRGINIA 25328
(304) 343-4371 OR 1-800-642-3049 (WV)
FAX (304) 353-0215

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

First lady visits Marshall, tours mobile clinic

First Lady Hillary Clinton posed for photographers with some of the people responsible for the mobile pediatric clinic: U.S. Sen. Jay Rockefeller, whose contributions and active leadership helped get the specialized van through the Children's Health Fund; Valley Health Systems Director Steve Shattls; clinic medical director Patricia Kelly, M.D., associate professor of pediatrics at Marshall; Dr. Ann Lambernedis, Marshall graduate and pediatrics resident; pediatric nurse practitioner Mary Kelly of Valley Health; and Dr. Mike Kilkenny of Wayne, a Marshall alumnus who now is Valley Health's medical director.

—Marshall University photo by Rick Haye

First Lady Hillary Rodham Clinton launched her tour to promote the Clinton administration's national health care reform initiative at Marshall on November 4.

In addressing a crowd estimated at 1,000, Clinton praised the school for its work in primary care. "I want to say a special word of thanks to the Marshall Medical School because of what you have done in primary and preventive health care," she said. "If every medical school had produced the number of physicians going into generalist practices, had been able to even compete for the Outstanding Rural Health Care Program Award this medical school won, had entered into partnerships like the one this medical school has with the Lincoln Primary Care Center, we would not have some of the problems we have today."

Afterward, Clinton spurned Secret Service agents' advice and took an impromptu tour of the mobile pediatric clinic that Marshall and Valley Health Systems operate in southern West Virginia.

Postgraduate residency training program for ob/gyns to start July 1

Beginning July 1, the Marshall University School of Medicine will offer postgraduate residency training to physicians specializing in obstetrics and gynecology.

The American Council on Graduate Medical Education has notified Marshall that the residency program has been accredited, according to Dr. Robert Nerhood, chairman of the Department of Obstetrics and Gynecology. The school can begin recruiting immediately to fill three slots per year.

Dr. Nerhood said the key factors in winning accreditation were a realistic strategic plan, the support of Huntington physicians and hospitals, and the addition of permanent core faculty, including subspecialists necessary for advanced training.

"Our five-year plan is to make the residency work, and work well," Dr. Nerhood said. "Our goal is to train residents to practice obstetrics and gynecology with a bias toward generalist care and toward providing that care using the mechanisms of rural health care. "We're interested in giving residents training first in the fundamental OB/GYN skills they need, second in the broader issues of primary care and prevention, and third in the skills that will enable them to function in a variety of health systems," he added.

Dr. Nerhood said the program also will be tied to the needs of rural West Virginia through a special emphasis on networking.

"Other schools' programs typically teach residents to work with other OBs and other specialists," Dr. Nerhood explained. "We'll also be teaching our residents to work with the nurse midwives, physician assistants and nurse practitioners who provide so much of the women's health care in rural communities. For our doctors to do well, they must be able to network with these other providers."

Highland Hospital

Inpatient Treatment Program for Schizophrenia or Schizoaffective Disorders

A treatment program is available with an investigational medicine for acute exacerbation of Chronic Schizophrenia or Schizoaffective Disorder.

This clinical trial is open to healthy males or healthy sterile females from 18-65 years of age. Patients must be able to give informed consent and agree to a four week hospital stay.

If medication is effective and participants wish to continue out-patient treatment with the medication, it can be provided for a one-year period. There is no charge for the inpatient or out-patient programs.

For more information, call: Charles C. Weise, M.D. at (304) 925-2159.

Highland Hospital is located at 56th Street and Noyes Avenue, S.E., Charleston.

Your CPA: The Right Choice

You need someone with honesty, ethics, education, integrity, independence, competence, reliability and objectivity. You've met your someone when you hire a CPA. As part of a profession, Certified Public Accountants hold strict standards of ethics and behavior, having passed a rigorous examination and met high educational requirements. Let a CPA's experience and knowledge work for you.

Whether your CPA is a company employee or an outside consultant, this professional brings many unique qualifications to your business. Management advisory services, accounting, auditing, financial and tax planning are just a few areas in which CPAs can be of service to you and your business. Members of The WV Society of CPAs bring integrity, independence, ethical standards and continuing education to their work, backed by the resources of a 1,700-member professional association.

MARSHALL UNIVERSITY

Medical Student News

Gear up for our Annual Meeting!

It is hard to believe that almost a year has passed since I was elected president of the West Virginia State Medical Association Medical Student Section. It has been an active and hectic year, and I am very grateful for the opportunity to have met and worked with so many of you.

As my year draws to close, it is time to remind you of the WVSMA-MSS Annual Meeting, which will take place during the WVSMA's Mid-Winter Clinical Conference at Lakeview Resort and Conference Center in Morgantown from January 20-24. Dr. Comerci has graciously offered to provide the MSS with its own free events and I hope that you will take full advantage of these activities. Our portion of the meeting will officially begin on Saturday morning, but there are two events on Friday evening which I think will be of special interest to medical students. The first is a reception hosted by the WVU and MU Schools of Medicine at 5:30 p.m. and the second is the Physician/Public Session entitled "Health System Reform: The States' Views," which will take place at 7 p.m. Dr. Comerci will moderate and be a speaker for this panel, which will also feature Ralph Crawshaw, M.D., of the University of Oregon Medical School, and Arnold Golodetz, M.D., of Burlington, Vt.

On Saturday, the MSS Annual Meeting will start at 8:30 a.m. with registration and a continental breakfast and a tentative schedule of events is as follows:

8:30 a.m.	**Registration with a continental breakfast**
9 a.m.	**Legislative workshop** **"Being Involved on the Local Level; How You Can Make a Difference"**
10:30 a.m.	**Break (visit the exhibits!)**
11:00 a.m.	**Drug company presentation (tentative)**
noon	**Luncheon** **Panel discussion: Organizing local chapter activities**
1 p.m.	**Business meeting with nominations for new state officers**

Please be reminded that anyone wishing to seek state office must attend the conference and should bring resume information, etc., to be distributed to the electorate. In accordance with the measure passed by the members at the 1993 MSS Annual Meeting, election this year will be conducted by mail-in-ballots after the members of the Executive Council take information regarding the candidates back to their respective chapters. An Election Committee to oversee the balloting procedures will be appointed at this year's annual meeting.

I want to take this opportunity to thank you for the chance to serve as your representative for the past year. The atmosphere of health care reform has made for an exciting term that has been interesting, at times frustrating, but always educational.

In closing, let me wish each of you a joy-filled and peaceful holiday season. I look forward to seeing you in Morgantown in January.

Mark S. Wright, MS IV
WVSMA-MSS President

P.S. Even though the events for medical students are free of charge, you must register so we will know how many students will be participating! Please turn to page 555 for the registration form.

Joseph G. Feghali, MD

Glaucoma Consultation and Surgery

Member of the American Glaucoma Society

- Specializes in pediatric and adult glaucoma
- Computerized optic nerve tomography: a quantitative scanning laser method to assess optic nerve tissue damage from glaucoma
- Glaucoma drainage implants: an established new surgical procedure for refractory and high-risk glaucoma cases

Joseph G. Feghali, MD - 2000 Hampton Center, Suite D - Morgantown, WV 26505
For appointments, call: (304) 599-6627 or (800) 333-6627

THE MYERS CLINIC — Philippi, West Virginia

Notice: Seeking Internal Medicine, Pediatrics, and/or Family Practice, must be Board Certified or Board Eligible.

Contact: Lonnie L. Crane, 112 North Woods Street, Philippi, WV 26416.
1-(304) 457-2800

Radiology:
Halberto G. Cruz, M. D.

Pathology:
Fulvio Franyutti, M. D.

Surgery:
J. W. Woodford, M. D.

Pediatrics:
E. G. Kreider, M. D.

Internal Medicine:
Karl J. Myers, Jr., M. D.
Z. Moussa, M. D.

Easter Seals

making a difference in the lives of West Virginians with disabilities

Two of the many services we provide include:

* State information and referral program connecting individuals with disabilities to appropriate agencies and professionals.
* State assistance program providing up to $100 for persons with documented needs to use toward evaluations, therapy and equipment.

For more information, contact:

Easter Seal Rehabilitation Center
1305 National Road
Wheeling, WV 26003
(304) 242-1390 Voice or TDD (304) 242-1390 or (800) 677-1390

1993 Index of Scientific Authors - Volume LXXXIX

A

Abrons, Henry L., MD (Discussant) - *Cystic Fibrosis: Current Concepts* (Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of WVU) June 236

Aburahma, Ali F., MD; Deniz F. Bastug, MD; Edward H. Tiley III, MD; Scott M. Killmer, MD; and James P. Boland, MD - *Management of Deep Vein Thrombosis of the Lower Extremity in Pregnancy* Oct. 445

B

Baker, Dreama Gail, MA, and M. Khalid Hasan, MD, FAPA, FRCP(C), MRC PSYCH(UK) - *Competency Assessment in the Elderly* Sept. 386

Bastug, Deniz F., MD; Ali F. Aburahma, MD; Edward H. Tiley III, MD; Scott M. Killmer, MD; and James P. Boland, MD - *Management of Deep Vein Thrombosis of the Lower Extremity in Pregnancy* Oct. 445

Boland, James P. MD; Ali F. Aburahma, MD; Deniz F. Bastug, MD; Edward H. Tiley III, MD; Scott M. Killmer, MD; and James P. Boland, MD - *Management of Deep Vein Thrombosis of the Lower Extremity in Pregnancy* Oct. 445

Buss, David H. MD; Alan W. Cashell, MD; and Christine A. Johnson, MD - *An Incidental Finding of Extreme Self-Limited Thrombocytosis of Unknown Cause* Dec. 545

C

Cashell, Alan W., MD; David H. Buss, MD; Christine A. Johnson, MD - *An Incidental Finding of Extreme Self-Limited Thrombocytosis of Unknown Cause* Dec. 545

Collins, Susan L., RN, MSN; Mitchell C. Sokolosky, MD; John E. Prescott, MD, FACEP; and Gregory A. Timberlake, MD, FACS - *Safety Belt Use and Hospital Charge Differences Among Motor Vehicle Crash Victims* Aug. 328

Cooper, Warren L. MD; Curtis D. White, MD; Rodney R. Williams, MD; and Albert Flemming, MD - *Choroidal Metastasis From Primary Mucinous Cystadenocarcinoma of the Ovary* April 146

Cooper, Warren L. MD; Curtis D. White, MD; and Rodney R. Williams, MD - *Management of Residual Squamous Intraepithelial Lesions of the Cervix After Conization* Sept. 382

Crowell, Edward B. Jr., MD, FACP, and Gerald M. Higa, Pharm. D. - *The Chemohormonal Therapy of Metastatic Melanoma: Possible Benefit of Tamoxifen* June 233

Crowell, Edward B. Jr., MD, FACP (Discussant) - *Breast Cancer - A Medical Disease?* (Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of WVU) Oct. 448

Cupit, Dennis, MSIV; Robert B. Walker, MD; Tim Thomas, MD; and Jennifer Giaquinto-Shreves, MSIII - *An Epidemic of Caterpillar Sting Dermatitis in a Rural West Virginia Community* Feb. 58

E

Elitsur, Yoram, MD, and Xia Liu, BS - *Hepatitis B Surface Antigen Prevalence in Blood Samples Tested at Cabell Huntington Hospital* Sept. 389

Elitsur, Yoram, MD, and Christoph U. Lehmann, MD - *PH Monitoring Experience in Children with Gastroesophageal Reflux* Dec. 538

Elliott, Sandra Y., MD; Fred T. Kerns, MD; and Lynn W. Kitchen, MD - *Herpes Esophagitis in Immunocompetent Adults: Report of Two Cases and Review of the Literature* May 188

F

Farr, R. Wesley, MD, and Hassan H. Ramadan, MD - *Report of Pseudomonas Aeruginosa Sinusitis in a Patient with Aids* July 284

Fisher, Melanie A., MD (Discussant) - *Chlamydia Trachomatis Genital Infections* (Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of WVU) Aug. 331

Flemming, Albert B.C., MD; Curtis D. White, MD; Warren L. Cooper, MD; and Rodney R. Williams, MD - *Choroidal Metastasis from Primary Mucinous Cystadenocarcinoma of the Ovary* April 146

G

Gharib, Mouna, MSII; Steven J. Jubelirer, MD; and Jason I. Smith, MSIII - *The Changing Pattern of Early Breast Cancer and its Primary Management at CAMC* Oct. 442

Giaquinto-Shreves, Jennifer, MSIII; Robert B. Walker, MD; Tim Thomas, MD; and Dennis Cupit, MSIV - *An Epidemic of Caterpillar Sting Dermatitis in a Rural West Virginia Community* Feb. 58

Gonzalez-Lavin, L., MD, FACS, FACC, FACCP, FAAP, and Mark J. Hermacinski, MD - *Simplified Method of Evaluating Dysfunction in St. Jude Medical Prosthetic Heart Valves* May 191

Graeber, Geoffrey M., MD, FACS; Gerald G. Tanguilig, MSII; and David R. Jones, MD - *Video-Assisted Thoracoscopy: A Major Advance in Diagnosis and Treatment of Intrathoracic Pathology* June 230

H

Hasan, M. Khalid, MD, FAPA, FRCP(C), MRC PSYCH(UK), and Dreama Gail Baker, MA - *Competency Assessment in the Elderly* Sept. 386

Hatfield, Lori, RN; Ronald McCowan, MD; Linda Tone, RN; Cliff Thorpe, CVT; Terry Miller, CVT; and Janis Kiser, RN - *Supraventricular Tachycardia: Catheter Ablation Therapy in 72 Patients* Aug. 324

Hermacinski, Mark J., MD, and L. Gonzales-Lavin, MD, FACS, FACC, FACCP, FAAP - *Simplified Method of Evaluating Dysfunction in St. Jude Medical Prosthetic Heart Valves* May 191

J

Jain, Abnash, MD, and L. Phillip Maxwell, MD (Discussants) - *Therapy for Congestive Health Failure in the Late 20th Century* (Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of WVU) April 148

Jones, David R., MD; Gerald G. Tanguilig, MSII; and Geoffrey M. Graeber, MD, FACS - *Video-Assisted Thoracoscopy: A Major Advance in Diagnosis and Treatment of Intrathoracic Pathology* June 230

Johnson, Christine A., MD; Alan W. Cashell, MD; and David H. Buss, MD - *An Incidental Finding of Extreme Self-Limited Thrombocytosis of Unknown Cause* Dec. 545

Jubelirer, Steven J., MD; and Marc Rubin, MSIII - *The Use of Modern Radiologic Methods in Identifying Incidental Renal Cell Carcinoma* Jan. 21

Jubelirer, Steven J., MD; Mark Rubin, MSIII; and Chull Shim, MD - *An Analysis of 38 Cases of Low-Grade Cerebral Astrocytoma in Adults* March 102

Jubelirer, Steven J., MD; Jason I. Smith, MSIII; and Mouna Gharib, MSIII - *The Changing Pattern of Early Breast Cancer and its Primary Management at CAMC* Oct. 442

K

Kaufman, Howard H., MD, and Joseph L. Voelker, MD - *Indications for Carotid Endarterectomy* March 106

Killmer, Scott M., MD; Ali F. Aburahma, MD; Deniz F. Bastug, MD; Edward H. Tiley III, MD; and James P. Boland, MD - *Management of Deep Vein Thrombosis of the Lower Extremity in Pregnancy* Oct. 445

Kiser, Janis, RN; Ronald McCowan, MD; Linda Tone, RN; Cliff Thorpe, CVT; Terry Miller, CVT; and Lori Hatfield, RN - *Supraventricular Tachycardia: Catheter Ablation Therapy in 72 Patients* Aug. 324

Kitchen, Lynn W., MD; Sandra Y. Elliott, MD; and Fred T. Kerns, MD - *Herpes Esophagitis in Immunocompetent Adults: Report of Two Cases and Review of the Literature* May 188

Kerns, Fred T.; Sandra Y. Elliott, MD; and Lynn W. Kitchen, MD - *Herpes Esophagitis in Immunocompetent Adults: Report of Two Cases and Review of the Literature* May 188

L

Lehmann, Christoph U., MD, and Yoram Elitsur, MD - *PH Monitoring Experience in Children With Gastroesophageal Reflux* Dec. 538

Lim, Jessica W., MD; Romeo Y. Lim, MD, FACS; and Samuel A. Strickland, MD - *Double Cheek-Cervical Rotation Flap for Repair of Facial Defects* Jan. 18

Lim, Romeo Y., MD, FACS - *Nd:Yag Laser Surgery of Venous Malformations* March 109

Lim, Romeo Y., MD, FACS; Samuel A. Strickland, MD; and Jessica W. Lim, MD - *Double Cheek-Cervical Rotation Flap for Repair of Facial Defects* Jan. 18

Liu, Xia, BS, and Elitsur, Yorum, MD - *Hepatitis B Surface Antigen Prevalence in Blood Samples Tested at Cabell Huntington Hospital* Sept. 389

M

Maxwell, L. Phillips, MD, and Abnash Jain, MD - (Discussants) - *Therapy for Congestive Health Failure in the Late 20th Century* (Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of WVU) April 148

McCowan, Ronald, MD - *Radiofrequency Catheter Ablation for Recurrent Ventricular Tachycardia* April 144

McCowan, Ronald, MD; Linda Tone, RN; Cliff Thorpe, CVT; Terry Miller, CVT; Janis Kiser, RN; and Lori Hatfield, RN - *Supraventricular Tachycardia: Catheter Ablation Therapy in 72 Patients* Aug. 324

Miller, Terry, CVT; Ronald McCowan, MD; Linda Tone, RN; Cliff Thorpe, CVT; Janis Kiser, RN; and Lori Hatfield, RN - *Supraventricular Tachycardia: Catheter Ablation Therapy in 72 Patients* Aug. 324

P

Pearson, R. John C., MD, MPH - *Cancer Mortality in West Virginia* Dec. 542

Pfister, Alfred K., MD, FACP - *An Implication for Bone Posterity: Dietary Calcium Intake in Medical Personnel in Southern West Virginia* July 280

Prescott, John E., MD, FACEP; Mitchell C. Sokolosky, MD; Susan L. Collins, RN, MSN; and Gregory A. Timberlake, MD, FACS - *Safety Belt Use and Hospital Charge Differences Among Motor Vehicle Crash Victims* Aug. 328

R

Ramadan, Hassan H., MD, and R. Wesley Farr, MD - *Report of Pseudomonas Aeruginosa Sinusitis in a Patient with Aids* July 284

Reisenweber, Harvey D., MD - *An "Above Ground" Pool Hazard* May 193

Rhodes, Larry A., MD, and Stanley B. Schmidt, MD - *Update On Therapy For Atrial Fibrillation* Nov. 490

Roger, John S. II, MD (Discussant) - *Hypercoagulable States* (Medical Grand Rounds from the Robert C. Byrd Health Sciences Center of WVU) April 61

Richmond, Bryan K., MD, and John H. Schmidt III, MD, FACS - *Giant Posterior Inferior Cerebellar Artery Aneurysm Associated with Foramen Magnum Syndrome* Nov. 494

Rubin, Mark, MSII; and Steven J. Jubelirer, MD - *The Use of Modern Radiologic Methods in Identifying Incidental Renal Cell Carcinoma* Jan. 21

Rubin, Mark, MSII; Steven J. Jubelirer, MD; and Chull Shim, MD - *An Analysis of 38 Cases of Low-Grade Cerebral Astrocytoma in Adults* March 102

S

Schmidt, John H. III, MD, FACS, and Bryan K. Richmond, MD - *Giant Posterior Inferior Cerebellar Artery Aneurysm Associated with Foramen Magnum Syndrome* Nov. 494

Schmidt, Stanley B., MD, and Larry A. Rhodes, MD - *Update on Therapy for Atrial Fibrillation* Nov. 490

Shim, Chull, MD; Steven J. Jubelirer, MD; and Mark Rubin, MSIII - *An Analysis of 38 Cases of Low-Grade Cerebral Astrocytoma in Adults* March 102

Smith, Jason I., MSII; Steven J. Jubelirer, MD; and Mouna Gharib, MSIII - *The Changing Pattern of Early Breast Cancer and its Primary Management at CAMC* Oct. 442

Sokolosky, Mitchell C., MD; John E. Prescott, MD, FACEP; Susan L. Collins, RN, MSN; and Gregory A. Timberlake, MD, FACS - *Safety Belt Use and Hospital Charge Differences Among Motor Vehicle Crash Victims* Aug. 328

Strickland, Samuel A., MD; Romeo Y. Lim, MD, FACS; and Jessica W. Lim, MD -*Double Cheek-Cervical Rotation Flap For Repair Of Facial Defects* Jan. 18

T

Tanguilig, Gerald G., MSII; David R. Jones, MD; and Geoffrey M. Graeber, MD, FACS - *Video-Assisted Thoracoscopy: A Major Advance in Diagnosis and Treatment of Intrathoracic Pathology* June 230

Thomas, Tim, MD; Robert B. Walker, MD; Dennis Cupit, MSIV; and Jennifer Giaquinto-Shreves, MSIII - *An Epidemic of Caterpillar Sting Dermatitis in a Rural West Virginia Community* Feb. 58

Thorpe, Cliff, C.V.T.; Ronald McCowan, MD; Linda Tone, RN; Terry Miller, CVT; Janis Kiser, RN; and Lori Hatfield, RN - *Supraventricular Tachycardia: Catheter Ablation Therapy in 72 Patients* Aug. 324

Tiley, Edward H. III, MD; Ali F. Aburahma, MD; Deniz F. Bastug, MD; Scott M. Killmer, MD; and James P. Boland, MD - *Management of Deep Vein Thrombosis of the Lower Extremity in Pregnancy* Oct. 445

Timberlake, Gregory A., MD, FACS; Mitchell C. Sokolosky, MD; John E. Prescott, MD, FACEP; and Susan Collins, RN, MSN - *Safety Belt Use and Hospital Charge Differences Among Motor Vehicle Crash Victims* Aug. 328

Tone, Linda, RN; Ronald McCowan, MD; Cliff Thorpe, CVT; Terry Miller, CVT; Janis Kiser, RN; and Lori Hatfield, RN - *Supraventricular Tachycardia: Catheter Ablation Therapy in 72 Patients* Aug. 324

V

Voelker, Joseph L., MD, and Howard H. Kaufman, MD - *Indications for Cartoid Endarterectomy* March 106

W

Walker, Robert B., MD; Tim Thomas, MD; Dennis Cupit, MSIV; and Jennifer Giaquinto-Shreves, MSIII - *An Epidemic of Caterpillar Sting Dermatitis in a Rural West Virginia Community* Feb. 58

White, Curtis D., MD; Warren L. Cooper, MD; Rodney R. Williams, MD; and Albert B.C. Flemming, MD - *Choroidal Metastasis from Primary Mucinous Cystadenocarcinoma of the Ovary* April 146

White, Curtis D., MD - *Papillary Intraperitoneal Neoplasia Resembling Ovarian Carcinoma After Removal of Benign Ovaries* July 273

White, Curtis D., MD; Warren L. Cooper, MD; and Rodney R. Williams, MD - *Management of Residual Squamous Intraepithelial Lesions of the Cervix After Conization* Sept. 382

White, Curtis D., MD - *The Gynecologist and Treatment of Carcinoma of the Breast* Nov. 496

Williams, Rodney R. MD; Curtis D. White, MD; Warren L. Cooper, MD; and Albert B.C. Flemming, MD - *Choroidal Metastasis from Primary Mucinous Cystadenocarcinoma of the Ovary* April 146

Williams, Rodney R., MD; Curtis D. White, MD; and Warren L. Cooper, MD -*Management of Residual Squamous Intraepithelial Lesions of the Cervix After Conization* Sept. 382

West Virginia Medical Journal

1994 ADVERTISING RATES

Full Page Color Advertisements:

Four Color, (back cover)	$925
Four Color, (inside back cover)	$825
Four Color, (inside)	$550
Spot Color	add $175

Black & White Advertisements:

Full Page, (inside front cover)	$450
Full Page, (inside back cover)	$450
Full Page, (back cover)	$500
Full Page, (inside)	$400

Ad Size	1x	3x	6x	12x
Color	$550	$525	$500	$475
Full Page B/W	$400	$375	$350	$300
1/2 Page	$225	$200	$175	$150
1/3 Page	$200	$175	$150	$125
1/6 Page	$175	$150	$125	$100

Sizes

Full Page	7 1/2" x 10"
1/2 Page (Horizontal)	7 1/2" x 4 3/4"
1/2 Page (Vertical)	3 1/2" x 10"
1/3 Page (Horizontal)	7 1/2" x 3 1/4"
1/3 Page (Vertical)	2 1/4" x 10"
1/6 Page (Vertical)	2 1/4" x 4 3/4"

Classified Ads

Each line measures 2 1/2 inches or 15 picas. The cost per line is $8 and there is a minimum charge of $40 per ad.

Subscription Rates

Single Copy	$3
United States	$36 per year
Foreign Countries	$60 per year

Classified

FAMILY PRACTICE FOR SALE - Large family practice in Charleston area for sale to board certified family physician or internist. Send inquiries to: P.O. Box 4106, Charleston, WV 25364

FOR SALE - Medical office for sale. Call 776-3328.

PHYSICIAN NEEDED - Board-Certified/ Board Eligible in Internal Medicine or Family Practice. Excellent benefit package. Huntington area. Please respond with curriculum vitae to: Physician, c/o RPMS, Inc., P.O. Box 1875 - SAXE, Huntington, WV 25719.

POSITION AVAILABLE IN WV - Established clinic with two locations seeks a family practitioner (either an M.D. or D.O.) to provide quality patient care in an immediate medical care facility. Attractive salary and benefit package including malpractice insurance. Contact Lin Sturdevant, Business Manager, Quick Care, 517 36th Street, Parkersburg, WV 26101 or (304) 485-1044.

RESOURCE TO PROFESSIONALS - We offer comprehensive practice and management services including selling, buying, valuing, recruiting, marketing, as well as transitions, mergers and associateships. Contact Resource To Professionals, Suite 800, USX Tower, Pittsburgh, PA 15219. (412) 288-4877.

Advertise

in the WV Medical Journal!
Call (304) 925-0342.

CLASSIFIED RATES: $5 per line, minimum of $25 per ad. One line equals 15 picas or 2 1/2 inches.

DEADLINE: Copy must be received by the 10th of the month preceding the month of issue. Send copy to: West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Don't Worry
about your
office supply problems,
call

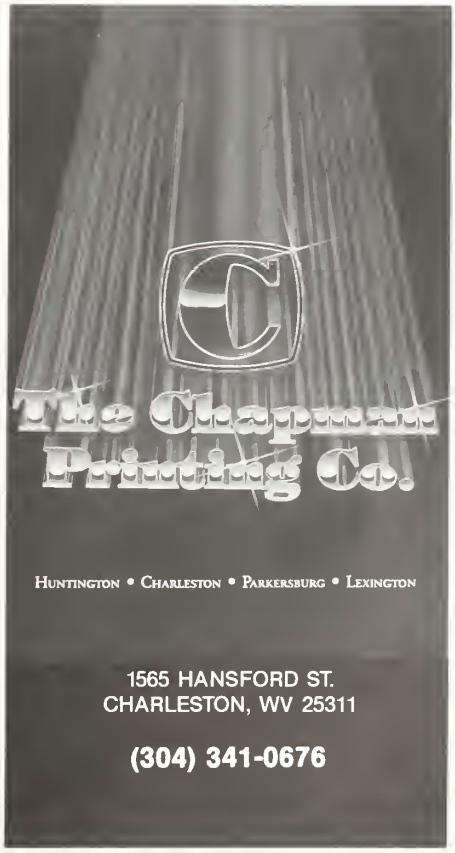
Stationers Incorporated
Your Office Supplier

1-800-862-7200
for solutions.
We Have It All!

* Value-priced office supplies
* Office Furniture
* Design Service
* Computer Supplies
* Standard Forms

Ask for our sales flyer!

STATIONERS
1945 5th Avenue
Huntington, WV 30428-2780



THE BEST OFFENSE

IS THE BEST DEFENSE.

Sixty years ago, few people had any hope of long-term survival against cancer. We were virtually defenseless.

Thanks to the American Cancer Society, that's changed. Our game plan emphasizes the fact that 80% of some cancers are not only defensible, but curable, if found and treated early.

Our strategy includes programs like "Special Touch," a woman's personal defense plan against breast cancer that could double the number of potentially lifesaving mammograms performed each year.

Call America's number one defensive coordinator at 1-800-ACS-2345. Together we can deal cancer a mighty blow.

AMERICAN CANCER SOCIETY®

THERE'S NOTHING MIGHTIER THAN THE SWORD.

December Advertisers

Associates in Obstetrics and Gynecology 541

Bristol-Myers Squibb Company ..... *Inside Back Cover, Back Cover*

Chapman Printing Company, The 569

CNA Insurance Company ..... *Inside Front Cover*

Easter Seal Rehabilitation Center 565

Eye & Ear Clinic of Charleston, Inc., The 561

Feghali, Joseph G., M.D. 565

HealthCare Financial Services 561

McDonough Caperton Insurance Group 532

Myers Clinic, The 565

Northern West Virginia Pain Management 547

Professional Medical Ultrasonics, Inc. .....

Radisson Hotel - Huntington .....

Smith Company Motor Cars .....

Stationers, Inc. .....

Turnkey Business Systems, Inc. .....

Vannoy, Daniel, J.D. .....

Weise, Charles C., M.D. .....

West Virginia Bureau of Public Health 5

West Virginia Chapter - American College of Surgeons .....

West Virginia Society of CPAs 5

A Dollar A Day

will help things go your way!

$365 Club

WESPAC has a new club - the $365 Club - or A Dollar A Day. Just think about it, a dollar a day can better help reform the health care system and protect your rights as physicians as well as the rights of your patients. Don't wait, the time to act is now!! **Send your personal check to WESPAC and become involved!**

WESPAC
P.O. Box 4106
Charleston, WV 25364

9465

10

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND, AT
BALTIMORE

NOT TO CIRCULATE

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE

NOT TO CIRCULATE

WERT
BOOKBINDING
Grantville, Pa
MAR. - APR. 1995
We're Quality Bound